United States Department of Labor
Employees' Compensation Appeals Board

P.H., Appellant	)	
and	)	**Docket No. 21-0233**
	)	**Issued: May 10, 2023**
U.S. POSTAL SERVICE, GOLDEN POST OFFICE, Denver, CO, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On December 1, 2020 appellant filed a timely appeal from a November 12, 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 over the merits of this case.

ISSUE

The issue is whether appellant has met her burden of proof to establish more than 89 percent permanent impairment of the right middle finger for which she has previously received a schedule award.

FACTUAL HISTORY

On December 24, 2011 appellant, then a 53-year-old city carrier, filed a traumatic injury claim (Form CA-1) alleging that on December 23, 2011 she slipped and fell on ice injuring her

[1] 5 U.S.C. § 8101 *et seq.*

face and right hand while in the performance of duty. She stopped work on December 27, 2011 and returned on January 3, 2012. On February 10, 2012 OWCP accepted the claim for closed fracture of the proximal phalanx of the right middle finger. On September 19, 2013 it expanded acceptance of appellant's claim to include contracture of the right finger joint and right hand osteoarthritis.

On November 26, 2013 appellant underwent arthrodesis of the right long finger proximal interphalangeal (PIP) joint and synovial biopsy.

Appellant filed a claim for compensation (Form CA-7) for a schedule award on July 1, 2014. By decision dated October 3, 2014, OWCP granted her a schedule award for 89 percent permanent impairment of her right middle finger. Appellant requested a review of the written record by a representative of OWCP's Branch of Hearings and Review. By decision dated March 12, 2015, OWCP's hearing representative affirmed the October 3, 2014 schedule award decision.[2]

On June 5, 2015 appellant underwent surgical removal of the hardware in her right long finger.

In a report dated August 4, 2015, Dr. Edmund Rowland, a Board-certified orthopedic surgeon, noted that appellant continued to experience difficulties with her right hand including the inability to grasp or grip. Appellant reported that she was unable to curl the index, right, and small fingers tightly into her palm. Dr. Rowland diagnosed painful end-stage right long finger PIP joint osteoarthritis with instability following fusion and hardware removal, awkward stiff finger, and the inability to tightly curl the index, ring, and small fingers on the right. He was unable to provide a definitive explanation for appellant's inability to curl her fingers and suggested that this was due to adhesions tethering the flexor digitorum profundus (FDP) and limiting its excursion.

In a letter dated January 20, 2016, appellant requested an additional schedule award alleging that she had additional permanent impairment of her right hand due to her accepted employment injury.[3]

Dr. Rowland completed a report and treatment notes on March 17, 2016 and indicated that he could not fully explain appellant's continued pain, tendon adhesions, and joint contractures of the right hand.

On May 12, 2016 the employing establishment noted that appellant was returning to regular duty on May 10, 2016.

Appellant filed a Form CA-7 requesting a schedule award on June 17, 2016. She provided a June 3, 2016 report from Dr. Gretchen Brunworth, a Board-certified physiatrist, noting appellant's December 23, 2011 employment injury and resulting medical treatment. Dr. Brunworth provided her findings on physical examination and noted that following the 2015

[2] On June 16, 2015 appellant appealed the March 12, 2015 decision to the Board. On October 7, 2015 she requested that the Board dismiss her appeal, which it did on January 20, 2016. Docket No. 15-1147 (issued January 20, 2016).

[3] On March 8, 2016 the Office of Personnel Management approved appellant's application for disability retirement.

surgery appellant had developed deficits in range of motion (ROM) of the second through fifth fingers of the right hand and was unable to make a full grip. She opined that appellant had developed adhesions of the palmar fascia limiting movement of the flexor tendons. Dr. Brunworth recommended physical therapy and found that appellant had not reached maximum medical improvement (MMI). However, she also provided an impairment rating.

On February 23, 2017 appellant filed a Form CA-7 requesting a schedule award. She submitted a report dated February 20, 2017 from Dr. Brunworth finding that she had reached MMI and addressing her permanent impairment. Dr. Brunworth noted appellant's history of injury and diagnosed fracture of the PIP joint of her right third digit with arthrodesis and severe end-stage osteoarthritis. She found ROM deficits in the second through fifth fingers on the right and noted that appellant was unable to make a full fist. Dr. Brunworth concluded that appellant had seven percent upper extremity impairment for the middle finger, eight percent upper extremity impairment for the index finger, eight percent impairment rating for fourth finger, and eight percent upper extremity impairment for the fifth finger. She combined appellant's impairment ratings to reach 27 percent permanent impairment of the right upper extremity.

On March 3, 2017 OWCP referred Dr. Brunworth's February 20, 2017 report, a statement of accepted facts (SOAF), a list of questions to the district medical adviser (DMA) Dr. David J. Slutsky, a Board-certified orthopedic surgeon, for review and determination of her permanent impairment for schedule award purposes. In a March 29, 2017 report, Dr. Slutsky found that Dr. Brunworth[4] did not provide any physical findings or medical reasoning in support of her permanent impairment calculations. He requested additional medical evidence addressing application of appellant's physical findings to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[5]

In an April 7, 2017 development letter, OWCP requested additional medical evidence from appellant in support of her schedule award claim and afforded her 30 days for a response.

Dr. Brunworth responded on May 2, 2017 and asserted that her June 3, 3026 report explained appellant's permanent impairment for schedule award purposes.

On August 8, 2017 the DMA found that Dr. Brunworth's[6] reports were insufficient to establish appellant's permanent impairment for schedule award purposes as appellant had not reached MMI at the time of the June 3, 2016 report and as the February 20, 2017 report did not contained findings or rationale in support of the impairment rating.

On December 1, 2017 OWCP referred appellant, a SOAF, and a series of questions for a second opinion evaluation of her permanent impairment for schedule award purposes with Dr. Richard Blecha, a Board-certified orthopedic surgeon.

[4] The DMA improperly attributed the June 3, 2016 report to Dr. Rowland rather than Dr. Brunworth.

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

[6] The DMA continued to attribute the June 3, 2016 and February 20, 2017 reports to Dr. Rowland rather than Dr. Brunworth.

In a January 4, 2018 report, Dr. Blecha reviewed the SOAF and medical records. He performed a physical examination and found that appellant had slight swelling of the PIP joint of the middle finger of the right hand. Dr. Blecha also found that her finger distal to the PIP joint was rotated medially a few degrees, that she had slight tenderness in all fingers. He measured ROM of the thumb and four fingers three times. Dr. Blecha noted that appellant had undergone additional finger surgery in 2015 and developed complications resulting in partial ankyloses of all the finger and to some degree the thumb. He found that, due to the consequential injuries resulting from the 2015 surgery, her whole hand should be rated for schedule award purposes. Dr. Blecha also found that appellant had reached MMI on December 15, 2016. He diagnosed ankyloses and arthrodesis apply Table 15-2, page 394, of the A.M.A., *Guides* which noted that motion loss may be assessed by Section 15.7, page 459, Range of Motion Impairment. Dr. Blecha found that appellant had 23 percent permanent impairment of the thumb or 9 percent permanent impairment of the right hand. He determined that she had 59 percent impairment of the index finger or 12 percent permanent impairment of the hand, 92 percent impairment of the middle finger or 18 percent impairment of the hand, 84 percent impairment of the ring finger or 8 percent impairment of the hand, and 74 percent impairment of the little finger or 7 percent impairment of the hand, for total right hand impairment of 54 percent or 41 percent impairment of the right upper extremity.

On February 19, 2018 the DMA reviewed Dr. Blecha's report and found that appellant had 80 percent impairment of the right middle finger which converted to 16 percent right hand impairment and 14 percent right upper extremity impairment. He opined that hardware removal from the PIP joint was a relatively minor procedure and would not be expected to result in multiple contractures involving the thumb and adjacent digits in the absence of a documented chronic regional pain syndrome and that therefore the impairment rating should be restricted to the middle finger.

In a letter dated May 17, 2018, OWCP found that there was a conflict of medical opinion evidence between Drs. Blecha and Slutsky requiring an impairment medical examination. It referred appellant, a SOAF, and a list of questions for examination by Dr. Michael Dunn, a Board-certified orthopedic surgeon.

On June 5, 2018 Dr. Dunn completed a report and diagnosed contracture of the right hand. He opined that appellant had reached MMI and found that her 24 percent permanent impairment of the right upper extremity based on loss of ROM in accordance with Table 15-30, Table 15-31, and Table 15-12 of the A.M.A., *Guides*.

On September 14, 2018 OWCP requested a supplemental report from Dr. Dunn providing a diagnoses, a detailed description of permanent impairment, and a discussion of the rationale for the calculation of appellant's permanent impairment rating based on the sixth edition of the A.M.A., *Guides*. Dr. Dunn submitted his June 5, 2018 treatment note.

On September 24, 2018 OWCP determined that Dr. Dunn was a second opinion physician, not an impartial medical examiner (IME) as there was no conflict of medical opinion between an OWCP physician and a physician for appellant at the time of his referral.

On February 6, 2019 OWCP referred appellant, a SOAF, and a series of questions for a second opinion evaluation with Dr. Raymond Topp, a Board-certified orthopedic surgeon, to determine her permanent impairment for schedule award purposes.

In a report dated February 26, 2019, Dr. Topp examined appellant and found that she had pain out of proportion to his examination. He found that the only appreciable casually-connected diagnosis was to the right middle finger due to PIP fusion and hardware removal. Dr. Topp found no signs of carpal tunnel syndrome. He recommended nerve conduction velocity (NCV) studies and a right-hand magnetic resonance imaging (MRI) scan. Dr. Topp found that appellant had reached MMI. He determined that her hardware removal surgery resulting in no further impairment to the middle finger. Dr. Topp found no reason to include the remaining aspects of the right hand and found no organic basis for the loss of ROM as appellant was resistant and had pain out of proportion. He concluded that she had no more than 89 percent permanent impairment of her right middle finger. Appellant underwent a right-hand MRI scan on March 18, 2019 which demonstrated bone marrow edema of the ulnar aspect of the right index finger metacarpal base or fracture. In a June 28, 2019 addendum, Dr. Topp reviewed the diagnostic studies and found that they confirmed that there was no evidence of carpal tunnel syndrome. He noted that appellant had baseline ulnar abutment syndrome which was chronic and unrelated to her accepted employment injury or resulting surgery.

In a September 1, 2019 report, the DMA found that Dr. Topp did not perform validated ROM measurements, did not provide the angle of ankyloses of the PIP or DIP joint. He concluded that appellant had no more than 89 percent permanent impairment of her right middle finger for which she had previously received a schedule award.

By decision dated September 11, 2019, OWCP denied appellant's claim for an increased schedule award. On October 10, 2019 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

On February 6, 2020 appellant testified before an OWCP hearing representative.

In a June 16, 2020 report, Dr. Michael James Sullivan, a Board-certified, examined appellant's right hand and diagnosed right-hand pain, trigger ring finger right hand, Dupuytren's disease, and limitation of joint motion of the right hand.

By decision dated October 9, 2020, OWCP's hearing representative set aside the September 11, 2019 decision and remanded the case for further development by OWCP, including additional review of the medical records by the DMA to determine whether carpal tunnel syndrome or ulnar abutment syndrome was causally related to the accepted work injury and whether appellant had additional permanent impairment warranting a schedule award.

On November 10, 2020 the DMA asserted that he was unable to comment on Dr. Topp's June 28, 2019 addendum regarding carpal tunnel syndrome or ulnar abutment syndrome as was it was not provided to him.

By decision dated November 12, 2020, OWCP denied appellant's claim for an additional schedule award.

LEGAL PRECEDENT

The schedule award provisions of FECA,[7] and its implementing federal regulations,[8] 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 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.[9] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[10]

In addressing impairment of the upper extremities, the sixth edition of the A.M.A., *Guides* request identify the impairment for the class of diagnosis (CDX), which is then adjusted by grade modifiers based on the grade modifier for functional history (GMFH), the grade modifier for physical examination (GMPE), and the grade modifier for clinical studies (GMCS).[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12] Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnosis from regional grids and calculations of modifier scores.[13]

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.[14] 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.[15] 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.[16]

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[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] *Id*. at § 10.404(a).

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

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

[12] *Id*. at 411.

[13] *R.A.*, Docket No. 19-1798 (issued November 4, 2020); *S.J.*, Docket No. 18-0966 (issued September 20, 2019); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

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

[15] *Id*. at 473.

[16] *Id*. at 474.

Regarding the application of ROM or diagnosis-based impairment (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 impairment rating for the diagnosis in question, the method producing the higher rating should be used*." (Emphasis in the original.)[17]
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> The Bulletin further advises:
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> "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 [claims examiner]."[18]

Before the A.M.A., *Guides* can be utilized, a description of the impairment must be obtained from his or her physician. In obtaining medical evidence required for a schedule award, the evaluation made by the attending physician must include a description of the impairment including, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decrease in strength or disturbance of sensation, or other pertinent descriptions of the impairment. This description must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations.[19]

A claimant may seek increased schedule award compensation if the evidence establishes that he or she sustained an increased impairment causally related to an employment injury.[20]

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

[18] *Id*.

[19] *A.T.*, Docket No. 18-0864 (issued October 9, 2018).

[20] *R.A.*, *supra* note 14, *Rose V. Ford*, 55 ECAB 449 (2004).

ANALYSIS

The Board finds that the case is not in posture for a decision as there remains an unresolved conflict of the medical opinion evidence regarding whether appellant has greater than 89 percent permanent impairment of her right middle finger due to her accepted conditions.

On June 5, 2015 appellant underwent surgical removal of the hardware in her right long finger. Following this surgery, her attending physicians consistently noted that she experienced loss of ROM of all the fingers in her right hand. On August 4, 2015 Dr. Rowland attributed this loss of ROM to adhesions arising from appellant's accepted surgeries tethering the FDP and limiting its excursion. On March 17, 2016 he found tendon adhesions and joint contractures of the right hand. In her June 3, 2016 report, Dr. Brunworth noted that following the 2015 surgery appellant had developed deficits in ROM of the second through fifth fingers of the right hand and was unable to make a full grip. She opined that appellant had developed adhesions of the palmar fascia limiting movement of the flexor tendons. On February 20, 2017 Dr. Brunworth found ROM deficits in the second through fifth fingers on the right and noted that appellant was unable to make a full fist.

On January 4, 2018 OWCP's second opinion physician, Dr. Blecha noted that appellant had undergone additional finger surgery in 2015 and developed complications resulting in partial ankyloses of all the finger and to some degree the thumb. He found that, due to the consequential injuries resulting from the 2015 surgery, appellant's whole hand should be rated for schedule award purposes.

In a February 19, 2018 report, OWCP's DMA, Dr. Slutsky, found that contrary to the opinions of Drs. Rowland and Brunworth, that hardware removal from the PIP joint was a relatively minor procedure and would not be expected to result in multiple contractures involving the thumb and adjacent digits in the absence of a documented chronic regional pain syndrome and that therefore the impairment rating should be restricted to the middle finger. On February 26, 2019 Dr. Topp, OWCP's second opinion physician, examined appellant that the only appreciable casually-connected diagnosis was to the right middle finger due to PIP fusion and hardware removal.

Section 8123(a) of FECA which provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician known as an IME who shall make an examination.[21] This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[22] When there exists opposing reports of virtually equal weight and rationale and the case is referred to an IME for the purpose

[21] 5 U.S.C. § 8123(a); *J.K.*, Docket No. 20-0907 (issued February 12, 2021); *R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009); *M.S.*, 58 ECAB 328 (2007).

[22] 20 C.F.R. § 10.321; *R.C.*, 58 ECAB 238 (2006).

of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[23]

OWCP improperly found that there was a conflict of medical opinion evidence between the DMA and Dr. Blecha, and designated Dr. Dunn, as the IME, to resolve this conflict.[24] On June 5, 2018 Dr. Dunn completed a report and diagnosed contracture of the right hand. As OWCP did not properly identify the conflict, it later determined that Dr. Dunn was, in fact, a second opinion examiner.[25] However, the Board finds that there remains an unresolved and unaddressed conflict in medical opinion between Drs. Slutsky and Topp, for OWCP and Drs. Rowland and Brunworth, for appellant.[26] The DMA and second opinion and appellant's physicians disagreed as to whether appellant had additional impairments of her right hand due to her accepted employment injury and resulting surgery. Consequently, the case must be referred to an IME to resolve the above-described conflict in the medical opinion evidence regarding appellant's permanent impairment due to her accepted conditions. On remand, OWCP shall refer appellant, along with the case file and an undated SOAF, to a specialist in the appropriate field of medicine for an impartial medical evaluation and report including a rationalized opinion on the issue of whether she has permanent impairment of her right hand as a consequence of her accepted employment injury and resulting surgeries. After this and other such further development as deemed necessary, it shall issue a *de novo* decision regarding appellant's schedule award claim.

CONCLUSION

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

[23] *See J.K., supra* note 22; *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

[24] *J.V.*, Docket No. 19-0269 (issued September 18, 2019).

[25] *Id*.

[26] *S.C.*, Docket No. 18-1450 (issued March 4, 2019).

ORDER

IT IS HEREBY ORDERED THAT the November 12, 2020 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further development consistent with this decision of the Board.

Issued: May 10, 2023
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board