United States Department of Labor
Employees' Compensation Appeals Board

R.L., Appellant	)	
and	)	**Docket No. 25-0045**
	)	**Issued: December 20, 2024**
DEPARTMENT OF JUSTICE, FEDERAL BUREAU OF PRISONS, FEDERAL CORRECTIONAL INSTITUTION HERLONG, Herlong, CA, 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
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On October 20, 2024 appellant filed a timely appeal from a September 19, 2024 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 his burden of proof to establish greater than eight percent permanent impairment of his left upper extremity, for which he previously received a schedule award.

[1] 5 U.S.C. § 8101 *et seq*.

FACTUAL HISTORY

On January 31, 2022 appellant, then a 35-year-old correctional officer, filed a traumatic injury claim (Form CA-1) alleging that on January 22, 2022 he injured his left wrist when attempting to open a jammed restroom door while in the performance of duty. He stopped work on January 24, 2022, and returned shortly thereafter. OWCP accepted the claim for triangular fibrocartilaginous complex (TFCC) tear, left wrist; radial styloid tenosynovitis (de Quervain's); and left wrist strain. On August 30, 2023 appellant underwent surgery for left wrist TFCC tear and left wrist synovitis. OWCP paid him wage-loss compensation on its supplemental rolls from August 30 through November 24, 2023. Appellant returned to full-time modified duty with restrictions on November 25, 2023.

Magnetic resonance imaging (MRI) scans of the left wrist dated February 14, 2022 and March 9, 2023 demonstrated de Quervain's and cysts, but that the TFCC was within normal limits.

On May 24, 2024 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In a March 26, 2024 report, Dr. Michael Lilyquist, a Board-certified orthopedic surgeon and hand and upper extremity surgery specialist, indicated that appellant continued to have pain in the ulnar aspect of his left wrist post TFCC debridement. He opined that appellant was at maximum medical improvement (MMI) and could return to full-duty work without restrictions.

On July 25, 2024 OWCP referred appellant, along with the medical record and a statement of accepted facts (SOAF) to Dr. Brian Bantum, a Board-certified physiatrist, for a second opinion examination and evaluation under the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*).[2]

In a report dated August 26, 2024, Dr. Bantum noted appellant's complaints of left wrist pain. He provided diagnoses of status post left TFCC tear, diagnosed intra-operatively; left de Quervain's tenosynovitis treated with occupational therapy, splinting and corticosteroid therapy; and resolved left wrist sprain/strain. Dr. Bantum reported that the physical evaluation of the left wrist revealed tenderness, decreased sensation and a mildly positive Finkelstein's test. Range of motion (ROM) examination of the left wrist, repeated on three measurements, revealed extension of 70 degrees, flexion of 60 degrees, radial deviation of 40 degrees, and ulnar deviation of 40 degrees. The motions of the uninjured right wrist were also provided. He utilized the diagnosis-based impairment (DBI) rating method to find, under Table 15-3 (Wrist Regional Grid), page 395, the class of diagnosis (CDX) for appellant's de Quervain's tenosynovitis resulted in a Class 1, grade A impairment with a default value of 1 percent. Dr. Bantum assigned a grade modifier for functional history (GMFH) of 1, a grade modifier for physical examination (GMPE) of 1, and a grade modifier for clinical studies (GMCS) of 1, noting that the MRI scan showed de Quervain's tenosynovitis. He utilized the net adjustment formula to find 0, which was equivalent to a grade C or 1 percent upper extremity impairment. Dr. Bantum also provided a DBI rating under Table 15-3, page 396 for the TFCC tear of the left wrist and found that the CDX resulted in a Class 1, grade C or eight percent permanent impairment. Dr. Bantum assigned GMFH

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

1, GMPE 1, and GMCS 0, noting that the diagnosis was made intra-operatively and the MRI scan did not show a TFCC tear. Under the net adjustment formula, he found a net adjustment of -2, which resulted in grade A or six percent upper extremity impairment. He combined the six percent upper extremity impairment for the TFCC tear and the one percent upper extremity impairment for the de Quervain's tenosynovitis and found seven percent left upper extremity impairment. Dr. Bantum reported that appellant reached MMI on March 26, 2024, the date Dr. Lilyquist reported.

On September 4, 2024 OWCP routed Dr. Bantum's August 26, 2024 report, along with the case record, and a statement of accepted facts (SOAF) to Dr. Herbert White, Jr., a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), for review and a determination of appellant's date of MMI and any permanent impairment of his left upper extremity under the sixth edition of the A.M.A., *Guides*. It further requested that Dr. White review Dr. Bantum's August 26, 2024 report and provide an opinion addressing whether he agreed with its findings.

In a September 13, 2024 report, Dr. White discussed the findings in Dr. Bantum's August 26, 2024 report. He opined that the date of MMI was August 26, 2024, the date of Dr. Bantum's impairment examination. Dr. White concurred with Dr. Bantum's DBI left upper extremity impairment rating of one percent for the de Quervain's but disagreed with Dr. Bantum's DBI left upper extremity impairment rating of six percent for the TFCC tear, explaining that the difference in the impairment values for the TFCC tear relied upon the rating for the GMCS. Dr. White noted that Dr. Bantum rated the GMCS as 0, having indicated that the clinical studies did not show any pathology, but explained that he rated the GMCS as 1 because the clinical studies showed the de Quervain's. He referred to the A.M.A., *Guides* and utilized the DBI rating method to find that, under Table 15-3, page 396, the CDX for appellant's left TFCC tear resulted in a Class 1 impairment with a default value of eight percent. Dr. White assigned a GMFH of 1, a GMPE of 1, and a GMCS of 1 and found the net adjustment formula resulted in 0, or final grade C for eight percent permanent impairment of the left upper extremity. He noted that under page 389 of the A.M.A., *Guides*, if more than one diagnosis in a region could be used, the one that provides the most clinically accurate causally-related impairment should be used. Typically, this will be the more specific diagnosis which adequately characterized the impairment and its impact on activities of daily living. Dr. White indicated that the TFCC tear was the most clinically accurate diagnosis and represented an eight percent permanent left upper extremity impairment. Regarding the ROM impairment rating method, he indicated that under Table 15-32, Wrist Range of Motion, page 473, flexion of 60 degrees equaled zero percent upper extremity impairment; extension 70 degrees equaled zero percent upper extremity impairment; radial deviation 40 degrees equaled zero percent upper extremity impairment; and ulnar deviation 40 degrees equaled zero percent upper extremity impairment for a total left upper extremity impairment of zero percent. Dr. White further noted that the A.M.A., *Guides* under Table 2-1, page 20, indicated that if there was more than one method to rate a particular impairment or condition, the method producing the higher rating must be used. As the DBI method produced the higher impairment rating, he concluded that appellant had eight percent permanent impairment of the left upper extremity.

By decision dated September 19, 2024, OWCP granted appellant a schedule award for eight percent permanent impairment of the left upper extremity. The award ran for 24.96 weeks from August 26, 2024 through February 16, 2025.

LEGAL PRECEDENT

The schedule award provisions of FECA,[3] and its implementing federal regulations,[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. 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.[5] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[6]

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology *versus* the ROM methodology for rating of upper extremity impairments.[7] FECA Bulletin No. 17-06 provides in pertinent part:

> "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*." (Emphasis in the original.)[8]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated. With respect to the wrist, the relevant portion of the arm for the present case, reference is made to Table 15-3 (Wrist Regional Grid) beginning on page 395. After the CDX is determined from the Wrist Regional Grid (including identification of a default grade value), the net adjustment formula is applied using a GMFH, GMPE, and/or GMCS. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[9] Under Chapter 2.3, evaluators are directed to

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[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] *Id.*

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

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

[8] *Id.*

[9] *See* A.M.A., *Guides* (6th ed. 2009) 405-12. Table 15-3 also provides that, if motion loss is present for a claimant with certain diagnosed wrist conditions, permanent impairment may alternatively be assessed using Section 15.7 (ROM impairment). Such an ROM rating stands alone and is not combined with a DBI rating. *Id.* at 397, 471-73.

provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[10]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[11]

ANALYSIS

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

OWCP referred the record to Dr. Bantum for a second opinion permanent impairment evaluation. In a report dated August 26, 2024, Dr. Bantum used Table 15-3 at page 395 of the A.M.A., *Guides* and noted that for the CDX of appellant's de Quervain's tenosynovitis, appellant had a Class 1 impairment with a default value of one percent. He then applied the grade modifiers and calculated a net adjustment of 0, which resulted in a grade C or one percent of the left upper extremity impairment. Dr. Bantum also used Table 15-3 at page 396 of the A.M.A., *Guides* and noted that for the CDX of TFCC tear with residual findings, appellant had a Class 1 impairment, with a default value of eight percent. He then applied the grade modifiers and, calculated a net adjustment of -2 which resulted in grade A or six percent upper extremity impairment. As previously noted, a proper calculation under the net adjustment formula would yield a net adjustment of -1, which would result in a grade B or seven percent permanent impairment of the left upper extremity.[12] Dr. Bantum also erroneously combined appellant's de Quervain's tenosynovitis impairment rating of one percent with the erroneously calculated six percent impairment for the TFCC tear, for a total of seven percent permanent impairment of the left upper extremity. The A.M.A., *Guides* at page 389 direct that if more than one diagnosis in a region could be used, the one that provides the most clinically accurate causally-related impairment should be used. Typically, this will be the more specific diagnosis which adequately characterized the impairment and its impact on activities of daily living. Thus, Dr. Bantum erred in combing the TFCC tear impairment value with the de Quervain's tenosynovitis impairment, as the more specific diagnosis which characterized the impairment and its impact on activities of daily living should have been chosen. He reported that appellant reached MMI on March 26, 2024. Although he provided ROM findings in the triplicate, Dr. Bantum did not provide an impairment rating under the ROM rating method. Thus, his impairment rating is of diminished probative value.

OWCP properly referred the evidence of record to the DMA, Dr. White, for review and an impairment rating. In his report dated September 13, 2024, Dr. White concurred with

[10] *Id*. at 23-28.

[11] *See supra* note 6 at Chapter 2.808.6f (March 2017). *See also B.C.*, Docket No. 21-0702 (issued March 25, 2022); *D.L.*, Docket No. 20-1016 (issued December 8, 2020); *P.W.*, Docket No. 19-1493 (issued August 12, 2020); *Frantz Ghassan*, 57 ECAB 349 (2006).

[12] *See supra* note 4.

Dr. Bantum's permanent impairment calculation of one percent for the de Quervain's tenosynovitis but disagreed with Dr. Bantum's permanent impairment calculations for the TFCC tear. Specifically, he took issue with Dr. Bantum's rating of the GMCS as 0, having indicated that the clinical studies did not show any pathology, and rated the GMCS as 1 because the clinical studies showed the de Quervain's. Under Table 15-3, page 396, Dr. White found the CDX for appellant's left TFCC tear resulted in a Class 1 impairment with a default value of eight percent. He then applied the grade modifiers and calculated a net adjustment of 0, which resulted in a grade C or eight percent impairment of the left upper extremity. Dr. White properly referred to page 389 of the A.M.A., *Guides* and found that the TFCC tear was the more specific diagnosis which adequately characterized the impairment and its impact on activities of daily living and concluded that appellant had eight percent permanent impairment of his left upper extremity. Dr. White further provided his impairment calculations under the ROM rating method. Under Table 15-32, page 473, of the A.M.A, *Guides*, he found flexion of 60 degrees equaled zero percent upper extremity impairment; extension 70 degrees equaled zero percent upper extremity impairment; radial deviation 40 degrees equaled zero percent upper extremity impairment; and ulnar deviation 40 degrees equaled zero percent upper extremity impairment for a total left upper extremity impairment of zero percent. Dr. White properly found, under Table 2-1, page 20, of the A.M.A., *Guides* that the DBI impairment rating method yielded the higher rating over the ROM method and found that appellant was entitled to a schedule award for eight percent permanent left upper extremity impairment. He further opined that appellant had reached MMI on August 26, 2024.

As there is no current medical evidence of record in conformance with the sixth edition of the A.M.A., *Guides* showing greater percentage than the eight percent permanent impairment of the left upper extremity previously awarded, the Board finds that appellant has not met his burden of proof.[13]

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 permanent impairment.

CONCLUSION

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

[13] *See T.F.*, Docket No. 24-0602 (issued September 11, 2024).

ORDER

IT IS HEREBY ORDERED THAT the September 19, 2024 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 20, 2024
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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