United States Department of Labor
Employees' Compensation Appeals Board

K.B., Appellant	)	
and	)	**Docket No. 23-0824**
	)	**Issued: October 24, 2024**
U.S. POSTAL SERVICE, POST OFFICE, Coppell, TX, 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
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On May 22, 2023 appellant filed a timely appeal from a December 20, 2022 merit decision of the Office of Workers' Compensation Programs (OWCP).[1] Pursuant to the Federal Employees' Compensation Act[2] (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 established any permanent impairment of the left upper extremity and/or greater than 80 percent permanent impairment of his right lower extremity, 54

[1] The Board notes that, following the December 20, 2022 decision, OWCP received additional evidence. The Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

[2] 5 U.S.C. § 8101 *et seq.*

percent of his left lower extremity, or 79 percent permanent impairment of his right upper extremity for which he previously received schedule award compensation.

FACTUAL HISTORY

On October 25, 1998 appellant, then a 28-year-old mail handler, filed an occupational disease claim (Form CA-2) alleging that on October 12, 1998 he first realized that he had developed bilateral plantar fasciitis while walking on hard floors in the course of his federal employment. OWCP accepted the claim for bilateral plantar fascial fibromatosis. It subsequently expanded the acceptance of the claim to include chronic pain syndrome due to bilateral plantar fasciitis and aggravation of anxiety and depressive disorders. Appellant stopped work on May 10, 1999 and returned to private sector employment on April 28, 2002.

On March 8, 2004 appellant filed a claim for compensation (Form CA-7) for a schedule award.

By decision dated June 9, 2005, OWCP granted appellant a schedule award for 63 percent permanent impairment of the right lower extremity and 54 percent permanent impairment of the left lower extremity pursuant to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3] The award ran for 336.96 weeks from April 14, 2005 through September 29, 2011.

On September 25, 2008 OWCP expanded the acceptance of the claim to include cellulitis of the foot, staphylococcus aureus septicemia, bilateral ulcers of the lower limbs, disorders of the circulatory system, bilateral tenosynovitis of the foot and ankle, bilateral fracture of the tibia or fibula, complications due to nervous system device implant and graft, and bilateral mononeuritis (peripheral neuropathy) of the upper extremities.

On October 2, 2018 OWCP further expanded the acceptance of the claim to include incisional hernia, umbilical hernias, cellulitis of the left upper extremity, right ankle primary osteoarthritis, right focal hyperhidrosis, amputation of the lower limb, and bilateral torsion dystonia.

In an August 23, 2018 report, Dr. John W. Ellis, a Board-certified family practitioner, described appellant's accepted conditions and medical treatment, found that he had reached maximum medical improvement (MMI), and evaluated his permanent impairment in accordance with the sixth edition of the A.M.A., *Guides*.[4] He calculated 73 percent permanent impairment of each upper extremity due to impairments of the median, ulnar, and radial peripheral nerves, 57 percent permanent impairment of the left lower extremity using the diagnosis-based impairment (DBI) method due to cellulitis, plantar fibromatosis, tenosynovitis, and impairments of the sural, common peroneal, and tibial peripheral nerves, and 81 percent permanent impairment of the right lower extremity due to amputation and sural nerve impairment.

[3] A.M.A., *Guides* (5th ed. 2001).

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

On September 24, 2018 appellant filed a Form CA-7 requesting an additional schedule award.

By decision dated May 15, 2020, OWCP granted appellant a schedule award for 79 percent permanent impairment of his right upper extremity pursuant to the sixth edition of the A.M.A., *Guides*. The award ran for 246.48 weeks from October 8, 2019 through June 28, 2024. The award was based on the findings of Dr. Adam Carter, a Board-certified physiatrist and an OWCP second opinion physician, who completed an October 8, 2019 report and the December 22, 2019 report from Dr. Morley Slutsky, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA).

On February 8, 2021 appellant filed a Form CA-7 claim for an additional schedule award.

In a development letter dated March 11, 2021, OWCP informed appellant of the deficiencies of his schedule award claim. It requested that he submit a detailed narrative medical report from his treating physician based on a recent examination, setting forth an opinion on the date of MMI and a rating of permanent impairment in accordance with the sixth edition of the A.M.A., *Guides*.

On July 6, 2021 OWCP referred appellant, a statement of accepted facts (SOAF), and a series of questions to Dr. James E. Butler, III, a Board-certified orthopedic surgeon, for a second opinion examination.

In a July 29, 2021 report, Dr. Butler reviewed both the SOAF and the medical record, and performed a physical examination. He found that diagnostic testing yielded mildly-decreased sensation in the median, radial, and ulnar nerves of the bilateral upper extremities. Dr. Butler further related that testing of the left common peroneal, left superficial peroneal, left medial plantar, left lateral planter, and left saphenous nerves in the right lower extremity demonstrated mildly-decreased sensation. He found normal motor strength in the upper extremities and noted normal motor strength in the bilateral hip flexors, leg extensors, hip extensors, leg flexors, hip abduction and hip adduction. Dr. Butler described 0/5 of motor strength in the left lower extremity in ankle dorsiflexion, ankle plantar flexion, ankle inversion, ankle eversion, great toe flexion, great toe extension, and extensor hallucis longus and noted appellant's right below the knee amputation. He also reported bilateral hand deformities. Dr. Butler provided three measurements of range of motion (ROM).

With regard to the right lower extremity, Dr. Butler applied the sixth edition of the A.M.A., *Guides* and found that appellant's amputation of less than three inches below the knee was assessed under Table 16-16, Amputation Impairment, page 542, as a Class 4, grade A impairment, which resulted in a rating of 80 percent permanent impairment. He assigned a grade modifier for functional history (GMFH) of 4, and a grade modifier for clinical studies (GMCS) of 0. Dr. Butler utilized the net adjustment formula which resulted in a grade A or 80 percent permanent impairment of the right lower extremity. With regard to the left lower extremity, he found that the DBI estimates should be used to rate appellant's left lower extremity due to the conditions of plantar fibromatosis and tendinitis, in accordance with Table 16-2, Foot and Ankle Regional Grid, page 501. Dr. Butler determined that GMFH was 2 in accordance with Table 16-6, page 516; that a grade modifier physical examination (GMPE) was not applicable, as ROM had been used to

determine class placement under A.M.A., *Guides*, page 517; and that GMCS was 0, in accordance with Table 16-8, page 519. He applied the net adjustment formula found on page 521 of the A.M.A., *Guides* and concluded that appellant had five percent permanent impairment of the left lower extremity. Dr. Butler then calculated his impairment rating based on peripheral nerve impairments in accordance with Table 16-12, page 534, and applied the net adjustment formula, finding 25 percent permanent impairment of the left lower extremity. With regard to the left upper extremity, he evaluated appellant's impairment in accordance with Table 15-21, Peripheral Nerve Impairment, page 438, and, after application of the net adjustment formula, found 12 percent permanent impairment of the left upper extremity.

On August 24, 2021 OWCP routed a SOAF and the medical record to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a DMA, for review and rating of appellant's permanent impairment under the sixth edition of the A.M.A., *Guides*.

In an August 25, 2021 report, Dr. Harris found that appellant had reached MMI on July 29, 2021, the date of Dr. Butler's evaluation. He concurred with Dr. Butler's impairment rating for the left upper extremity, but determined that when properly combined appellant had 13 percent impairment of the left upper extremity due to ulnar nerve, medial nerve, and radial nerve sensory impairments. The DMA further agreed that appellant had 80 percent permanent impairment of the right lower extremity for below the knee amputation. He determined that appellant had five percent permanent impairment of the left lower extremity due to ankle sprain and plantar fibromatosis with mild motion deficits. The DMA concurred with Dr. Butler's findings of mild impaired sensation of the saphenous, sural, common peroneal, superficial peroneal, medial plantar, and lateral plantar nerves, resulting in 25 percent left lower extremity impairment. He noted that appellant had previously received schedule award compensation for 54 percent permanent impairment of the left lower extremity and 79 percent of the right upper extremity and, as such, there was no increase in his right upper or left lower extremity impairments.

By decision dated October 4, 2021, OWCP granted appellant a schedule award for an additional 17 percent permanent impairment of his right lower extremity (for a total of 80 percent), based on the opinions of Dr. Butler and Dr. Harris. The award ran for 336 weeks from October 18, 2019 through March 16, 2026. OWCP denied appellant's claim for additional schedule awards for the left lower and right upper extremities, finding that the medical evidence was insufficient to establish greater than the 54 percent permanent impairment of the left lower extremity and 79 percent permanent impairment of the right upper extremity previously awarded.

On October 3, 2022, appellant requested reconsideration. He noted that his primary concern was his left upper extremity. While appellant's original Form CA-7 schedule award claim included all of his extremities, OWCP failed to address permanent impairment of his left upper extremity. Appellant argued that "every extremity should've been done at the same time especially when Dr. Carter includes my left upper extremity which was totally missed."

By decision dated December 20, 2022, OWCP denied modification of its prior decision.

LEGAL PRECEDENT

The schedule award provisions of FECA[5] and its implementing regulations[6] 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 of a member 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 has adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[7] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[8] 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.[9]

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): A Contemporary Model of Disablement*.[10] In evaluating lower extremity impairment, the sixth edition requires identifying the impairment class of diagnosis (CDX), which is then adjusted by GMFH, GMPE, and 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 diagnoses from regional grids and calculations of modifier scores.[13] The standards for evaluation of permanent impairment of an extremity under the A.M.A., *Guides* are based on all factors that prevent a limb from functioning normally, such as pain, sensory deficit, and loss of strength.[14]

In addressing 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

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[5] *Supra* note 2.

[6] 20 C.F.R. § 10.404.

[7] *Id.*; *see D.C.,* Docket No. 20-0916 (issued September 14, 2021); *see also Ronald R. Kraynak*, 53 ECAB 130 (2001).

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

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

[10] A.M.A., *Guides* (6th ed. 2009), p.3, section 1.3.

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

[12] *Id.* at 411.

[13] *See M.P.,* Docket No. 18-1298 (issued April 12, 2019); *R.V.,* Docket No. 10-1827 (issued April 1, 2011).

[14] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see J.C.,* Docket No. 21-0288 (issued July 1, 2021); *N.D.,* 59 ECAB 344 (2008); *Tania R. Keka*, 55 ECAB 354 (2004).

to be rated.[15] After a CDX is determined (including identification of a default grade value), the impairment class is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[16] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[17]

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)."[18]

FECA Bulletin further advises:

> "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.)[19]

The Bulletin also 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."[20]

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

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[15] *B.B.,* Docket No. 20-1187 (issued November 18, 2021); *M.D.,* Docket No. 20-0007 (issued May 13, 2020); *P.R.,* Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, *supra* note 9.

[16] A.M.A., *Guides* 383-492; *see B.B., id.*; *M.P.,* Docket No. 13-2087 (issued April 8, 2014).

[17] *Id.*

[18] FECA Bulletin No. 17-06 (issued May 8, 2017); *B.B., supra* note 15; *V.L.,* Docket No. 18-0760 (issued November 13, 2018).

[19] *Id.*

[20] *Id.*

of impairment in accordance with the A.M.A., *Guides*, with OWCP's medical adviser providing rationale for the percentage of impairment specified.[21]

ANALYSIS

The Board finds that appellant has established that he sustained 13 percent permanent impairment of the left upper extremity, warranting a schedule award.

OWCP referred appellant to Dr. Butler for a second opinion examination and opinion regarding the permanent impairment of his extremities. In a report dated July 29, 2021, Dr. Butler evaluated appellant's left upper extremity impairment in accordance with Table 15-21, Peripheral Nerve Impairment, page 438, and, after application of the net adjustment formula, found 12 percent permanent impairment of the left upper extremity.

Consistent with its procedures, OWCP properly referred the case record to Dr. Harris, serving as DMA, for an opinion regarding appellant's permanent impairment in accordance with the sixth edition of the A.M.A., *Guides*.[22] In his August 25, 2021 report, Dr. Harris found that appellant had reached MMI on July 29, 2021, the date of Dr. Butler's evaluation. He concurred with Dr. Butler's impairment rating for the left upper extremity but determined that when properly combined appellant had 13 percent impairment of the left upper extremity due to ulnar nerve, medial nerve and radial nerve sensory impairments.

The Board finds that the DMA, Dr. Harris, properly considered the findings contained in the July 29, 2021 impairment evaluation, as reviewed and approved by Dr. Butler, and explained that appellant's current impairment was 13 percent total permanent impairment of the left upper extremity based on ulnar nerve, medial nerve, and radial nerve sensory impairments. In addition, the DMA properly utilized the DBI method and considered the ROM method to rate appellant's accepted upper extremity condition pursuant to FECA Bulletin No. 17-06.

Therefore, the Board finds that appellant has established 13 percent permanent impairment of the left upper extremity, based upon the reports of Dr. Butler and DMA Dr. Harris. Consequently, OWCP's December 20, 2022 decision must be reversed, and the case returned to OWCP for payment of the schedule award for 13 percent permanent impairment of the left upper extremity.

The Board further finds that appellant has not established greater than 80 percent permanent impairment of his right lower extremity, 54 percent of his left lower extremity, or 79 percent permanent impairment of his right upper extremity for which he previously received schedule award compensation.

In his July 29, 2021 report, Dr. Butler found that appellant's right leg amputation of less than three inches below the knee was assessed under Table 16-16, Amputation Impairment, page 542, as a Class 4, grade C impairment, which resulted in a rating of 80 percent permanent

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[21] *See supra* note 8 at Chapter 2.808.6f (March 2017).

[22] *Supra* note 16.

impairment. With regard to the left lower extremity, he found that the DBI estimates should be used to rate appellant's left lower extremity due to the conditions of tendonitis with moderate motion deficits and/or significant weakness, in accordance with Table 16-2, Foot and Ankle Regional Grid, page 501. Dr. Butler determined that the grade modifiers and the net adjustment formula concluded that appellant had five percent permanent impairment of the left lower extremity. He then calculated his impairment rating based on peripheral nerve impairments in accordance with Table 16-12, page 534, and applied the net adjustment formula, finding 25 percent permanent impairment of the left lower extremity.

In his August 25, 2021 report, Dr. Harris, the DMA, concurred with Dr. Butler's permanent impairment calculations for both lower extremities. He explained that appellant had no greater than 80 percent permanent impairment of his right lower extremity, 54 percent of his left lower extremity, or 79 percent permanent impairment of his right upper extremity for which he previously received schedule award compensation. As noted, when the prior impairment is due to a previous employment injury and a schedule award has been granted for such prior impairment, the percentage already paid is subtracted from the total percentage of impairment.[23] Thus, the DMA properly found that appellant was not entitled to an additional schedule award for either the right upper extremity or the bilateral lower extremities.

As there is no current medical evidence of record in conformance with the sixth edition of the A.M.A., *Guides* showing a greater percentage of permanent impairment than the 80 percent permanent impairment of appellant's right lower extremity, 54 percent of his left lower extremity, or 79 percent permanent impairment of his right upper extremity that which was previously awarded, the Board finds that 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 permanent impairment.

CONCLUSION

The Board finds that appellant has established 13 percent permanent impairment of the left upper extremity. The Board further finds that appellant has not established greater than 80 percent permanent impairment of his right lower extremity, 54 percent of his left lower extremity, or 79 percent permanent impairment of his right upper extremity for which he previously received schedule award compensation.

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[23] 20 C.F.R. § 10.404(d); *see L.R.,* Docket No. 24-0257 (issued May 1, 2024); *T.W.*, Docket No. 23-0357 (issued September 7, 2023); *S.M.*, Docket No. 17-1826 (issued February 26, 2018); *T.S.*, Docket No. 16-1406 (issued August 9, 2017).

ORDER

IT IS HEREBY ORDERED THAT the December 20, 2022 decision of the Office of Workers' Compensation Programs is reversed in part and affirmed in part consistent with this decision of the Board.

Issued: October 24, 2024
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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