United States Department of Labor
Employees' Compensation Appeals Board

K.W., Appellant	)	
and	)	**Docket No. 12-1281**
	)	**Issued: January 9, 2013**
DEPARTMENT OF THE NAVY, PUGET SOUND NAVAL SHIPYARD, Bremerton, WA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 16, 2012 appellant filed a timely appeal from a November 23, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP) regarding her schedule award.[1] Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2 and 501.3, the Board has jurisdiction over the merits of the case.

[1] Under the Board's Rules of Procedure, the 180-day time period for determining jurisdiction is computed beginning on the day following the date of OWCP's decision. *See* 20 C.F.R. § 501.3(f)(2). As OWCP's schedule award decision was issued on November 23, 2011, the 180-day computation begins November 24, 2011. One hundred and eighty days from November 24, 2011 was May 22, 2012. Since using May 24, 2012, the date the appeal was received by the Clerk of the Board, would result in the loss of appeal rights, the date of the postmark is considered the date of filing. The date of the U.S. Postal Service postmark is May 16, 2012, which renders the appeal timely filed. *See* 20 C.F.R. § 501.3(f)(1).

[2] 5 U.S.C. §§ 8101-8193.

ISSUE

The issue is whether appellant has more than six percent impairment of her left upper extremity and seven percent impairment of her right lower extremity, for which she received a schedule award.

FACTUAL HISTORY

On June 8, 2005 appellant, then a 28-year-old machinist, sustained multiple injuries when she was struck by a van while crossing an intersection in a crosswalk. OWCP accepted a right leg fracture (tibia, fibula and femur) with open reduction and internal fixation; left wrist dislocation and fracture (at the radial carpal joint) with open reduction; fractured left radius (forearm); fractured left humerus (upper arm); fractured left clavicle, fracture of the superior ramus on the right; pelvis fracture; facial and head contusions; back strain; fracture of the pubic bone; and acute reaction to stress. Appellant underwent multiple surgeries on June 9 and 10, 2005. Following a period of modified duty in 2006, the employing establishment terminated appellant's employment effective July 12, 2006 as it could no longer accommodate her with modified duty. In a September 28, 2007 decision, OWCP reduced her compensation based on a finding that the selected position of secretary represented her wage-earning capacity. On June 17, 2008 OWCP's hearing representative affirmed the September 28, 2007 decision.

On July 25, 2011 appellant requested a schedule award. In a September 12, 2011 report, Dr. Timothy Gilmore, Board-certified in family practice and occupational medicine, noted the history of injury and presented examination findings. He opined that appellant was at maximum medical improvement with permanent impairment related to the left arm, right leg and pelvic fractures. Dr. Gilmore indicated that there were neurologic findings on the lower extremity, range of motion and weakness problems on the upper extremity and she had incontinence problems related to the pelvic fracture and pelvic disruption. Under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), he opined that appellant had 15 percent impairment of the whole person as a consequence of her work-related injuries. Dr. Gilmore attributed five percent whole person impairment for the pelvic fracture. Under Table 17-11, page 593, he stated that appellant had a class 1 injury due to fracture of the pelvis. Dr. Gilmore noted that page 592 of the A.M.A., *Guides* indicated that the consequences of the pelvic fracture needed to be considered and that she had stress incontinence and dyspareunia. Under Table 7-4, page 139, he assigned a class 1, grade C bladder impairment which equated to five percent whole person impairment with no adjustment for Physical Examination (GMPE) or Clinical Studies (GMCS). Dr. Gilmore accorded 10 percent upper extremity impairment or six person whole person impairment due to fracture-dislocation of the left wrist (radius & ulna fractures). He noted that appellant had loss of range of motion in radial and ulnar deviation and intermittent paresthesias and loss of strength in the hand. Under Table 15-3, Dr. Gilmore opined that she was a class 1, grade C. Under Table 15-6, Table 15-7 and Table 15-32, he found that appellant had grade 2 modifier for Functional History (GMFH) and grade 2 modifier for physical examination which, after applying the net adjustment formula, resulted in an adjustment of +2 which moved the default grade C rating two places into a grade E or 10 percent arm impairment. For proximal right tibia-fibula fractures, Dr. Gilmore opined that there was six percent right leg impairment or two percent whole person impairment. Under Table 16-3, he opined that appellant had a class 1 tibial injury. Dr. Gilmore

found a grade 2 functional history modifier and grade 1 physical findings modifier with no modifier for clinical studies, resulting in an adjustment of 1 or grade D or six percent leg impairment. For right sural nerve damage, he found four percent right lower extremity impairment or two percent whole person impairment. Under Table 16-12, page 534, Dr. Gilmore found a class 1 injury for the right sural nerve with a grade 2 modifier for functional history but no adjustment for physical examination or clinical studies. Under the net adjustment formula, this equated to a grade D or four percent impairment of the left leg. Dr. Gilmore used the Combined Values Chart to find appellant had 15 percent impairment of the whole person.

In an October 12, 2011 report, OWCP's medical adviser reviewed the matter. While he agreed that appellant reached maximum medical improvement, he was unable to concur with Dr. Gilmore's ratings. For the left wrist, the medical adviser stated that Dr. Gilmore appeared to use the impairment class for the diagnosed condition (CDX) of wrist dislocation under Table 15-3, page 396, but noted that, as no instability was found on examination, a zero percent impairment results under that diagnosis. He indicated that the most appropriate diagnosis under Table 15-3, page 396 was "fracture with residual symptoms, consistent objective findings and/or functional loss, with normal motion and appellant was class 1 with a default grade of C or three percent impairment. The medical adviser noted that the presence or absence of prior surgery did not change the diagnosed condition or the class. He additionally stated that since appellant did not have normal motion, the range of motion method could be used to rate impairment. Under Table 15-32, page 473, the medical adviser found six percent upper extremity impairment. He noted flexion of 70 degrees and extension of 80 degrees equated to no impairment; radial deviation of 10 degrees yielded two percent impairment and ulnar deviation 10 degrees yielded four percent impairment. The medical adviser noted that the range of motion method yielded the highest possible impairment at six percent and thus was preferred.

For the right leg, OWCP's medical adviser noted that, under page 389, the single diagnosed condition with the highest rating should be used and, for that reason, sural nerve impairment should not be rated separately. He also noted that appellant's symptoms were intermittent and an electromyography and nerve conduction studies in that area were completely normal, which indicated that the nerve was intact. Thus, the medical adviser stated that the sural nerve dysfunction should be considered part of the grade modifier for physical examination rather than a separate ratable condition. Under Table 16-3, page 511, he stated that a proximal tibia shift fracture, nondisplaced with abnormal examination findings and less than 10 degrees of angulation was a class 1 impairment with a default grade of C or five percent lower extremity impairment. The medical adviser noted that the grade modifier for functional history was 2 per Dr. Gilmore and grade modifier physical examination was 2 based on the symptoms and findings related to the sural nerve. No knee instability was noted. The medical adviser noted grade modifiers for clinical studies were not applicable as the imaging studies were the basis for the diagnosis being rated. Under the net adjustment formula, he found (GMFH -- CDX) (2-1) + (GMPE -- CDX) (2-1) equated +2, which changed the grade from C to E which resulted in seven percent right lower extremity impairment.

OWCP's medical adviser stated that there was no lower extremity impairment for the pelvis injury. He noted that the original records indicated a single minimally displaced fracture of a single pubic ramus and no multiple closed pelvic fractures and no disruption of the pelvic floor. The medical adviser additionally noted that Dr. Gilmore found that the only complaint

attributed to the pelvis was urinary stress incontinence and that he had rated impairment under the bladder dysfunction table (Table 7-4, page 139) rather than the pelvis. He also noted that Dr. Gilmore did not examine or test the bladder and all of his information was taken from appellant. The medical adviser further noted that appellant's stress incontinence was a common residual from child birth. He opined that regardless of the cause, there was no lower extremity impairment from the pelvis fracture.

In a November 23, 2011 decision, OWCP granted appellant a schedule award for six percent impairment of the left arm and seven percent impairment of the right leg. The award ran from November 20, 2011 to August 18, 2012 for a total of 38.88 weeks.

LEGAL PRECEDENT

The schedule award provision 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, it 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] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2008.[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, for upper and lower extremity impairments the evaluator identifies the impairment class for the diagnosed condition, which is then adjusted by grade modifiers based on functional history, physical examination and clinical studies.[8] The net adjustment formula is (GMFH -- CDX) + (GMPE -- CDX) + (GMCS -- CDX).[9] Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[10]

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[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] *Id.* at § 10.404(a).

[6] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[7] A.M.A., *Guides* (6th ed. 2008), page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[8] *Id*. at 385-419.

[9] *Id.* at 411.

[10] *J.W.*, Docket No. 11-289 (issued September 12, 2011).

The sixth edition of the A.M.A., *Guides* also provides that range of motion (ROM) may be selected as an alternative approach in rating impairment under certain circumstances. A rating that is calculated using ROM may not be combined with a diagnosis-based impairment and stands alone as a rating.[11]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the percentage of impairment using the A.M.A., *Guides.*[12]

ANALYSIS

OWCP accepted that appellant sustained a right leg fracture (tibia, fibula and femur) with open reduction and internal fixation; left wrist dislocation and fracture (at the radial carpal joint) with open reduction; fractured left radius (forearm); fractured left humerus (upper arm); fractured left clavicle, fracture of the superior ramus on the right; pelvis fracture; facial and head contusions; back strain; fracture of the pubic bone; and acute reaction to stress due to her June 8, 2005 employment injury. On November 23, 2011 it granted her a schedule award for six percent left arm impairment and seven percent right leg impairment. The Board finds that OWCP properly relied on Dr. Gilmore's clinical findings, as interpreted by the medical adviser, to find that appellant had six percent left upper extremity impairment and seven percent right lower extremity impairment.

The sixth edition of the A.M.A., *Guides* states that diagnosis-based impairment is the primary method of evaluation for the upper limb and the method of choice for calculating impairment.[13] On the other hand, ROM-based impairment may be used as a stand-alone rating when other grids refer the evaluator to this method or when no other diagnosis-based sections are applicable for impairment rating of a condition.[14] With respect to wrist diagnoses, Table 15-3 on page 396 of the A.M.A., *Guides* contains an asterisk footnote that directs the evaluator to the following postscript: If motion loss is present, this impairment may alternatively be assessed using section 15.7, ROM impairment. A ROM impairment stands alone and is not combined with diagnosis impairment.[15]

With regards to the left upper extremity, Dr. Gilmore appeared to evaluate appellant's left wrist condition for the diagnosed condition of wrist sprain with history of dislocation including carpal instability under Table 15-3, page 396. However, he did not document any instability on examination, which is required for a class 1 impairment under that diagnosis. As Dr. Gilmore did not provide any rationale for his impairment rating choice, including the diagnoses chosen

[11] *W.T.*, Docket No. 11-1994 (issued May 22, 2012).

[12] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

[13] A.M.A., *Guides* 397 and 461.

[14] *Id.* at 397.

[15] *Id.* at 405.

from Table 15-3 and his calculation of modifier scores, his calculated rating is of limited probative value.[16] The medical adviser noted that, under Table 15-3, page 396, the most appropriate diagnosis was a class 1 fracture with residual symptoms, consistent objective findings and/or functional loss, with normal motion for a class C or three percent impairment. However, since lost ROM is present, the impairment can be rated under the ROM method. The medical adviser properly analyzed appellant's left wrist condition under the ROM method to find a six percent left upper extremity impairment. Under Table 15-32, page 473, he properly found 70 degrees of flexion and 80 degrees of extension yielded no impairment; while 10 degrees radial deviation equaled two percent impairment and 10 degrees ulnar deviation equaled to four percent impairment. As noted, a ROM impairment stands alone. There is no other medical report providing impairment greater than six percent for the left upper extremity.

For the right leg, Dr. Gilmore attributed impairment based on the pelvis injury, the tibia-fibula fractures and sural nerve damage. While he indicated that appellant had impairment for the pelvis injury, he provided impairment for a bladder dysfunction. Neither FECA nor OWCP regulations provide a schedule award for the bladder.[17] No schedule award is payable for a member, function or organ of the body not specified in FECA or in the implementing regulations. FECA does not provide for OWCP to add organs or functions to the compensation scheduled on a case-by-case basis and the Board does not have the power to enlarge the provisions of either statute or regulations.[18] Thus, Dr. Gilmore's impairment finding is of little probative value with regards to bladder dysfunction. The medical adviser opined that there was no lower extremity impairment for the pelvis injury and provided medical rationale for his opinion based on appellant's medical records and Dr. Gilmore's clinical findings. Thus, his opinion regarding no impairment for the pelvis injury is accorded determinative weight.

Dr. Gilmore opined that appellant had six percent impairment for right tibial-fibula fractures and four percent impairment from sural nerve damage to the right lower extremity. The medical adviser disagreed that the sural nerve damage should stand alone as an impairment; opining that it should be considered part of the physical examination grade modifier for the diagnosed condition of tibula-fibula fractures, which would result in a seven percent lower extremity impairment. The Board notes that both Dr. Gilmore and OWCP's medical adviser found the tibial shaft fracture was class 1 with default class C or five percent lower extremity impairment under Table 16-3, page 511 of the A.M.A., *Guides* and applied modifiers for functional history and physical examination to obtain their impairment rating. While the medical adviser opined that the sural nerve damage should be considered part of the physical examination modifier, Dr. Gilmore rated it separately under Table 16-2. There is nothing in the A.M.A., *Guides* provisions which discourages either approach.[19] Moreover, the choice rests within the

[16] *J.W., supra* note 10. *See Linda Beale*, 57 ECAB 429 (2006) (when the attending physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides*, his opinion is of diminished probative value).

[17] 5 U.S.C. § 8107(c); *supra* note 4.

[18] *D.J.*, Docket No. 11-1359 (issued February 24, 2012).

[19] Section 16.4 provides that peripheral nerve impairment may be combined with diagnosed-based impairments at the lower extremity level when the diagnosed-based impairment does not already include nerve impairment. A.M.A., *Guides* 531.

sound discretion of the evaluating physician.[20] Therefore, the Board finds that a conflict in medical opinion exists between Dr. Gilmore and OWCP's medical adviser regarding the proper method by which to rate appellant's right lower extremity impairment based on the diagnosed fractures and sural nerve damage.[21] Where there is a conflict in medical opinion between the employee's physician and the physician making the examination for the United States or an OWCP medical adviser, OWCP shall appoint a third physician, known as a referee physician or impartial medical specialist, to make what is called a referee examination.[22] To resolve the present matter, OWCP shall remand the case and refer appellant, together with the medical evidence of record and a statement of accepted facts, to a Board-certified specialist for a referee examination. The specialist shall determine which evaluation method is appropriate and provide sound reasoning to support both the choice of method and the calculation of impairment under specific tables in the A.M.A., *Guides.* After conducting such further development as deemed necessary, OWCP shall render an appropriate decision on appellant's entitlement to an additional award.[23]

CONCLUSION

The Board finds that appellant has not established that she sustained more than six percent impairment of the left upper extremity and the case is not in posture for decision regarding the impairment of the right lower extremity.

[20] *C.M.*, Docket No. 11-1282 (issued December 20, 2011).

[21] *Id.*

[22] *See* 5 U.S.C. § 8123(a); 20 C.F.R. § 10.321. *See also R.A.*, Docket No. 09-552 (issued November 13, 2009).

[23] *C.M.*, Docket No. 11-1283 (issued December 20, 2011). In light of the Board's disposition of this case, appellant's arguments on appeal will not be addressed.

ORDER

IT IS HEREBY ORDERED THAT the November 23, 2011 decision of the Office of Workers' Compensation Programs is affirmed in part and set aside in part and the case remanded for further action consistent with this decision of the Board.

Issued: January 9, 2013
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board