



radius with ulna when he was thrown from an all-terrain vehicle while descending an incline. He stopped work on March 22, 2010. Appellant returned to modified-duty work on April 25, 2010 and regular-duty work on November 17, 2010.

On March 26, 2010 Dr. Mark D. Jacobson, an attending Board-certified orthopedic surgeon, performed an open reduction and internal fixation of radial shaft fracture with six-hole plate, fluoroscopy of radius, ulna and distal radio-ulnar joint and pinning of distal radio-ulnar joint. The procedures were authorized by OWCP.<sup>2</sup>

After surgery, appellant participated in regular physical therapy sessions. In an August 4, 2010 report, Dr. Jacobson advised that appellant's left arm was much suppler and much less tender to palpation. He stated that appellant could return to full-duty work except for driving four-wheel vehicles. On September 8, 2010 Dr. Jacobson noted that appellant could return to driving all-terrain vehicles in about a month.

In a November 17, 2010 report, Dr. Jacobson stated that appellant reported that he felt great and was performing full-duty work. He occasionally had some pain over his left wrist and forearm, but he was able to perform push-ups and engage in other rigorous exercise. Physical examination revealed well-healed scars on the left arm with sensation intact. For the left wrist, appellant had 90 degrees of extension, 80 degrees of flexion, 30 degrees of ulnar deviation, 15 degrees of radial deviation, 90 degrees of supination and 90 degrees of pronation. Dr. Jacobson stated that appellant suffered two injuries, a fracture of the left distal radius and disruption of the left triangular fibrocartilage complex and distal radial ulnar joint. He opined that, for rating purposes, appellant's fracture had healed without problems and was, therefore, class 0 with no residual findings after surgical treatment. Dr. Jacobson noted that appellant's triangular fibrocartilage complex tear had mild symptoms with mild strength deficit and stated:

“Using the Class of Diagnosis Regional Grid System of the sixth edition of the [American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)], his net adjustment is equal to [c]lass 1 [triangular fibrocartilage complex] tear. From Table 15-3, [appellant's] grade modifier for functional history is 1. His grade modifier for physical examination is 1. [Appellant's] grade modifier for clinical studies is 0. Using this formula and the formula net adjustment equals (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX). The overall modifier is -1. Thus using Table 15-3 the [triangular fibrocartilage complex] impairment moves from the default value of [eight percent] to [seven percent] in the B column and, therefore, [seven percent] of upper extremity functional impairment.”<sup>3</sup>

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<sup>2</sup> On May 5, 2010 Dr. Jacobson removed the hardware from the surgery. In several reports, he referred to appellant's condition as being a Galeazzi fracture, a type of fracture of the radius with dislocation of the distal radio-ulnar joint.

<sup>3</sup> Dr. Jacobson stated, “The patient's injury to the upper extremity was 100 percent due to employment and incurred in the course of duty.”

In a November 17, 2010 note, Dr. Jacobson found that appellant could return to full-duty work with no restrictions.

On June 6, 2011 appellant filed a claim for a schedule award due to his March 22, 2010 work injuries.

In January 2012, OWCP requested that Dr. Christopher R. Brigham, a Board-certified occupational medicine physician serving as an OWCP medical consultant, provide an opinion on appellant's left arm impairment.

On February 6, 2012 Dr. Brigham discussed appellant's accepted work injuries and reviewed the November 17, 2010 report of Dr. Jacobson which noted a seven percent permanent impairment of appellant's left arm. He posited that Dr. Jacobson provided an impairment rating for a diagnosis, triangular fibrocartilage complex tear, which was not supported by the objective evidence. He stated that the correct diagnosis to rate appellant's impairment was based on a wrist fracture. Dr. Brigham noted that appellant had a diagnosis of a Galeazzi fracture/dislocation and that sometimes this type of dislocation could cause a disruption of the distal radio-ulnar joint and a triangular fibrocartilage complex tear. His review of appellant's March 26, 2010 surgery did not confirm that a triangular fibrocartilage complex tear was identified, nor was a repair of a triangular fibrocartilage complex tear performed. Dr. Brigham stated that the objective evidence did not support a rating for a triangular fibrocartilage complex tear.

Under Table 15-3 on page 396 of the sixth edition of the A.M.A., *Guides*, Dr. Brigham provided a diagnosis-based impairment on appellant's wrist fracture as class 1 with a default value of three percent for the left arm. He stated that Dr. Jacobson's selection of a grade modifier 1 for functional history was not warranted because appellant was able to perform full-duty work and engage in rigorous exercise. Under Table 15-7 on page 406, appellant had a grade modifier 0 for functional history due to the fact that he had "no problem" in this category. Under Table 15-8 on page 408, the findings of record showed that appellant fell under grade modifier 0 for physical examination and that, under Table 15-9 on pages 410 and 411, a grade modifier was not applicable for clinical studies. Dr. Brigham noted that application of the Net Adjustment Formula meant that appellant's left arm rating moved two places to the left on Table 15-3 and yielded a diagnosis-based impairment rating of one percent. He then applied the range of motion rating method, found in Table 15-32 on page 473 of the A.M.A., *Guides* to determine that appellant's 15 degrees of radial deviation of the left wrist equaled a two percent impairment of the left arm. Dr. Brigham stated that, because the range of motion rating method yielded a higher impairment for appellant's left arm, it should be used rather than the diagnosis-based rating method. He concluded that appellant had a two percent permanent impairment of his left arm.

In a February 24, 2012 decision, OWCP granted appellant a schedule award for a two percent permanent impairment of his left arm. The award ran for 6.24 weeks from November 17 to December 30, 2010. OWCP based the award on Dr. Brigham's impairment rating which evaluated the findings of Dr. Jacobson.

On October 15, 2012 appellant requested reconsideration and submitted images from diagnostic testing of his left arm. One of the images contained the handwritten notation, “Plate of fracture of radial shaft (not a wrist fracture).” Appellant also submitted documents which were already in the record.

In a January 17, 2013 decision, OWCP affirmed its February 24, 2012 decision, finding that appellant had not established more than a two percent permanent impairment of his left arm. It found that Dr. Brigham’s assessment of appellant’s left arm impairment was proper and that he explained why the higher rating of Dr. Jacobson was not made in accordance with the standards of the A.M.A., *Guides*.

### **LEGAL PRECEDENT**

The schedule award provision of FECA<sup>4</sup> and its implementing regulations<sup>5</sup> 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. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.<sup>6</sup> For OWCP decisions issued on or after May 1, 2009, the sixth edition of the A.M.A., *Guides* (6<sup>th</sup> ed. 2009) is used for evaluating permanent impairment.<sup>7</sup> It is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included.<sup>8</sup>

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 Class of Diagnosis (CDX) is determined from the Wrist Regional Grid (including identification of a default grade value), the Net Adjustment Formula is applied using the grade modifier for Functional History (GMFH), grade modifier for Physical Examination (GMPE) and grade modifier for Clinical Studies (GMCS). The Net Adjustment Formula is (GMFH - CDX) +

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<sup>4</sup> 5 U.S.C. § 8107.

<sup>5</sup> 20 C.F.R. § 10.404 (1999).

<sup>6</sup> *Id.*

<sup>7</sup> See FECA Bulletin No. 9-03 (issued March 15, 2009). For OWCP decisions issued before May 1, 2009, the fifth edition of the A.M.A., *Guides* (5<sup>th</sup> ed. 2001) is used.

<sup>8</sup> See *Dale B. Larson*, 41 ECAB 481, 490 (1990); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.b. (June 1993). This portion of OWCP’s procedures provide that the impairment rating of a given scheduled member should include “any preexisting permanent impairment of the same member or function.”

(GMPE - CDX) + (GMCS - CDX).<sup>9</sup> Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.<sup>10</sup>

### ANALYSIS

OWCP accepted that on March 22, 2010 appellant sustained a closed fracture of his radius shaft with ulna and a closed fracture of his distal radius with ulna. On March 26, 2010 Dr. Jacobson, an attending Board-certified orthopedic surgeon, performed an open reduction and internal fixation of radial shaft fracture with six-hole plate, fluoroscopy of radius, ulna and distal radio-ulnar joint and pinning of distal radio-ulnar joint. On February 6, 2012 Dr. Brigham, Board-certified in occupational medicine and serving as an OWCP medical adviser, reviewed the evidence of record. He determined that appellant had a two percent permanent impairment of his left wrist under the sixth edition of the A.M.A., *Guides*. In a February 24, 2012 decision, OWCP granted appellant a schedule award for a two percent permanent impairment of his left arm based on Dr. Brigham's ratings.

The Board finds that appellant did not meet his burden of proof to establish that he has more than a two percent permanent impairment of his left arm. Dr. Brigham provided a proper assessment of appellant's left arm impairment under the standards of the sixth edition of the A.M.A., *Guides*.

On February 6, 2012 Dr. Brigham indicated that he had reviewed the November 17, 2010 report in which Dr. Jacobson found that appellant had a seven percent permanent impairment of his left arm and he correctly noted that Dr. Jacobson provided an impairment rating for a diagnosis, triangular fibrocartilage complex tear, which was not supported by the objective evidence. He indicated that appellant had a diagnosis of a Galeazzi fracture/dislocation and that sometimes this type of dislocation can cause a disruption of the distal radio-ulnar joint and cause a triangular fibrocartilage complex tear. Dr. Brigham stated that a review of the report for appellant's March 26, 2010 surgery did not confirm that a triangular fibrocartilage complex tear was identified and that a repair of a triangular fibrocartilage complex tear was not performed on that date. Therefore, the objective evidence did not support a rating for a triangular fibrocartilage complex tear. The Board notes that appellant's claim has not been accepted for a triangular fibrocartilage complex tear and finds that the record does not support that he sustained such a condition due to his March 22, 2010 work injury or that he had a preexisting impairment due to a triangular fibrocartilage complex tear.<sup>11</sup> It is noted that Dr. Jacobson first diagnosed a triangular fibrocartilage complex tear in his November 17, 2010 report and that he did not provide support for this diagnosis, such as the findings of diagnostic testing. The Board finds

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<sup>9</sup> See A.M.A., *Guides* (6<sup>th</sup> ed. 2009) 395-97. Table 15-3 also provides that, if motion loss is present for a claimant who has sustained a wrist fracture, impairment may alternatively be assessed using section 15.7 (range of motion impairment). Such a range of motion impairment stands alone and is not combined with a diagnosis-based impairment. *Id.* at 397, 473-78.

<sup>10</sup> *Id.* at 23-28.

<sup>11</sup> See *supra* note 8 regarding preexisting impairments.

that, therefore, that Dr. Brigham properly concluded that his impairment rating of seven percent of the left arm was not made in accordance with the standards of the A.M.A., *Guides*.

Dr. Brigham first conducted a diagnosis-based impairment rating which was based on appellant's left wrist fracture.<sup>12</sup> Under Table 15-3, appellant's wrist fracture would fall under class 1 with a default value of three percent for the left arm. Dr. Brigham explained his findings for the functional history, physical examination and clinical studies grade modifiers. He noted that application of the Net Adjustment Formula meant that appellant's left arm rating moved two places to the left on Table 15-3 and yielded a diagnosis-based impairment rating for the left arm of one percent. Dr. Brigham then applied the range of motion rating method, found at Table 15-32 on page 473, to determine that appellant's 15 degrees of radial deviation of the left wrist equaled a two percent impairment of the left arm. He found that, because the range of motion rating method yielded a higher impairment rating for appellant's left arm, it should be used rather than the diagnosis-based rating method.<sup>13</sup> Dr. Brigham correctly concluded that appellant had a two percent permanent impairment of his left arm.

Appellant has argued that his left arm impairment rating should have been based on the seven percent rating of Dr. Jacobson. However, for the reasons explained above, Dr. Brigham has provided the only impairment rating of record that comports with the relevant standards of the A.M.A., *Guides*. On appeal, appellant suggested that his continuing symptoms of left wrist pain warranted a higher impairment rating, but his own opinion of the degree of his left arm impairment would not have probative value. He has not shown that he has more than a two percent permanent impairment of his left arm, for which he received a schedule award. Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

### CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that he has more than a two percent permanent impairment of his left arm, for which he received a schedule award.

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<sup>12</sup> The Board notes that appellant's accepted condition can properly be referred to as a left wrist fracture on a shorthand basis, whereas more specifically it constitutes fracture/dislocation of the left radius shaft/distal radius and ulna.

<sup>13</sup> See *supra* note 9.

**ORDER**

**IT IS HEREBY ORDERED THAT** the January 17, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 26, 2013  
Washington, DC

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

Patricia Howard Fitzgerald, Judge  
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge  
Employees' Compensation Appeals Board