United States Department of Labor
Employees' Compensation Appeals Board

W.M., Appellant	)	
and	)	**Docket No. 14-953**
	)	**Issued: August 13, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Cincinnati, OH, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA HOWARD FITZGERALD, Acting Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On March 20, 2014 appellant filed a timely appeal from a February 24, 2014 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 established that he sustained more than 13 percent impairment of the left upper extremity, for which he received a schedule award.

FACTUAL HISTORY

On June 27, 2011 appellant, then a 58-year-old distribution clerk, filed a traumatic injury claim alleging that on May 2, 2011 the wire cage he was pushing off a truck got caught on the ramp and his thumb bent back at the base. OWCP accepted the claim for aggravation of

[1] 5 U.S.C. §§ 8101-8193.

preexisting left hand osteoarthritis. It paid appropriate compensation benefits, including a January 4, 2012 left thumb fusion. Appellant returned to full duty on April 4, 2012.

Under claim number xxxxxx989, OWCP accepted the condition of bilateral lateral epicondylitis. Appellant underwent authorized right elbow surgery (fasciotomy) on September 19, 1997 and left elbow surgery (fasciotomy) on October 20, 1997. On June 30, 1999 he received three percent impairment to the right upper extremity and two percent impairment to the left upper extremity. On August 4, 2000 appellant received an additional one percent impairment to the right upper extremity and three percent to the left upper extremity. On June 12, 2001 he received an additional seven percent impairment to the left upper extremity. These totaled 4 percent for the right upper extremity and 12 percent for the left upper extremity.

On July 5, 2012 appellant filed a claim for an increased schedule award for permanent partial impairment in connection with the thumb injury. On July 10, 2012 OWCP sent a letter to appellant's treating physician, Dr. Craig Willis, a Board-certified orthopedic surgeon, requesting his opinion as to whether he had any permanent impairment under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A, *Guides*). No response was received from Dr. Willis.

In an August 3, 2012 report, Dr. Martin Fritzhand, an occupational medicine physician, opined that appellant reached maximum medical improvement in July 2012 and that he had sustained 12 percent left upper extremity impairment. He provided physical examination findings and cited to tables within the A.M.A., *Guides* and explained his impairment rating. On September 6, 2012 an OWCP medical adviser reviewed Dr. Fritzhand's August 3, 2012 examination findings and concurred with the 12 percent left upper extremity impairment rating. However, neither Dr. Fritzhand nor the medical adviser had taken into consideration the previous schedule award for the accepted medical conditions under claim number xxxxxx989.

On May 2, 2013 OWCP prepared a statement of accepted facts and wrote to Dr. Fritzhand requesting an assessment of the left upper extremity impairment based on the accepted conditions under the current claim and claim number xxxxxx989, for which he had received prior schedule awards.

In a May 30, 2013 report, Dr. Fritzhand reviewed the statement of accepted facts and presented examination findings. He found left elbow flexion to be 140 degrees, forearm supination to 60 degrees, forearm pronation to 80 degrees, left thumb flexion to 40 degrees, normal extension to zero degrees, abduction to 20 degrees, and 5 centimeter adduction. Citing Table 15-30 of the A.M.A., *Guides* for a range of motion rating, Dr. Fritzhand determined 13 percent impairment of the left thumb due to range of motion. He found 35 percent digital impairment, by adding 3 percent interphalangeal (IP) joint flexion digital impairment; IP joint extension 1 percent; metacarpophalangeal (MCP) flexion 4 percent, MCP extension 0 percent; carpometacarpal (CMC) adduction 8 percent, radial abduction 10 percent; and opposition 9 percent. Dr. Fritzhand then used Table 12-2 to convert the 35 percent digital impairment of the left thumb to 13 percent upper extremity impairment. Citing Table 15-4 (regional elbow grid), he opined that 5 percent impairment due to epicondylitis. Dr. Fritzhand noted that under Table 15-7 grade modifier Functional History (GMFH) 1 based on *Quick*DASH score 64; Table 15-8 grade modifier Physical Examination (GMPE) 1; Table 15-9 grade modifier Clinical Studies

(GMCS) 1, which equated to zero grade modifiers. He opined that maximum medical improvement was met by January 2013 and appellant had 5 percent left upper extremity impairment referable to the 1996 injury and an additional 13 percent impairment referable to the 2011 injury, for a combined 17 percent left upper extremity impairment. On June 22, 2013 an OWCP medical adviser reviewed Dr. Fritzhand's May 30, 2013 report and found that there needed to be three sets of range of motion measurements to be valid.

In a September 13, 2013 addendum, Dr. Fritzhand provided the results of three sets of thumb range of motion measurements which had been conducted September 10, 2013 and which covered the IP joint flexion (30, 40, 45), IP joint extension (0, 0, 0), adduction (20, 25, 20), opposition (2 centimeters (cm), 4 cm, 2 cm), MCP joint flexion (20, 20, 30), and MCP joint extension (0, 0, 0). Citing Table 15-30, Dr. Fritzhand determined that appellant had 35 percent left thumb impairment. Citing Table 15-12, Dr. Fritzhand converted 35 percent digit impairment to 13 percent left upper extremity impairment. He reiterated his opinion that appellant had 17 percent combined left upper extremity impairment.

In a September 26, 2013 report, an OWCP medical adviser found that Dr. Fritzhand's range of motion measurements were valid. He opined that maximum medical improvement had been reached on September 10, 2013, the date of Dr. Fritzhand's examination. The medical adviser calculated 21 percent left thumb impairment based on Dr. Fritzhand's examination findings. Under Table 15-30, he found 3 percent for 50 degrees IP flexion loss; 1 percent for 0 percent IP extension loss, 4 percent for 30 degrees MCP flexion loss, 0 percent for 0 degrees MCP extension (no loss), 4 percent for 5 cm adduction, 5 percent for 30 degrees abduction, and 4 percent for 4 degrees opposition. Under Table 15-35, the medical adviser found thumb range of motion was equal to grade modifier 2. Under Table 15-7, he found grade modifier functional history was 1 as opposed to Dr. Fritzhand's rating of 3 as there was no mention that appellant required modifications to perform self-care activities and thus a grade modifier of 2 secondary to the *Quick*DASH form as calculated by Dr. Fritzhand was not necessary. Under Table 15-35, the final adjustment between range of motion GMFH (2) -- range of motion grade modifier 1 equaled 1, which equated to 21 percent left thumb digit impairment. Under Table 16-12, the medical adviser converted the 21 percent left thumb impairment to 8 percent left upper extremity impairment. He combined the 8 percent left upper extremity impairment for the thumb and 5 percent impairment from the 1996 epicondylitis to find a total 13 percent left upper extremity impairment.

By decision dated October 4, 2013, OWCP awarded appellant a schedule award for an additional one percent left upper extremity impairment. It noted that appellant was previously awarded a total 12 percent impairment for the left upper extremity (3 percent on August 4, 2000, 7 percent on June 12, 2001, and 2 percent June 30, 1999) and as the present impairment was 13 percent, he was due an additional 1 percent impairment. The weight of the medical evidence was given to the medical adviser's opinion.

On October 25, 2013 appellant requested a review of the written evidence of record by an OWCP hearing representative. He indicated in an October 25, 2013 statement that he had continued weakness and loss of agility in his left hand and arm. Copies of Dr. Fritzhand's May 20 and September 30, 2013 reports were submitted.

By decision dated February 24, 2014, an OWCP hearing representative affirmed OWCP's October 4, 2013 decision.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations 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.[2] 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.[3]

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). For upper extremity impairments, the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on functional history, physical examination and clinical studies. The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[4] Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[5]

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 percentage of impairment using the A.M.A., *Guides*.[6]

In some instances, OWCP's medical adviser's opinion can constitute the weight of the medical evidence. This occurs in schedule award cases where an opinion on the percentage of permanent impairment and a description of physical findings is on file from an examining physician, but the percentage estimate by this physician is not based on the A.M.A., *Guides.* In this instance, a detailed opinion by OWCP's medical adviser which gives a percentage based on reported findings and the A.M.A., *Guides* may constitute the weight of the medical evidence.[7]

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[2] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[3] *K.H.,* Docket No. 09-341 (issued December 30, 2011). For decisions issued after May 1, 2009, the sixth edition will be applied. *B.M.*, Docket No. 09-2231 (issued May 14, 2010).

[4] *R.Z.,* Docket No. 10-1915 (issued May 19, 2011).

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

[6] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.808.6(d) (August 2002).

[7] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence,* Chapter 2.810.8(j) (September 2010).

OWCP procedures state that any previous impairment to the member under consideration is included in calculating the percentage of loss, except when the prior impairment is due to a previous work-related injury, in which case the percentage already paid is subtracted from the total percentage of impairment.[8]

ANALYSIS

OWCP accepted appellant's claim for aggravation of localized primary osteoarthritis, left hand. It authorized a left thumb/hand surgery on January 10, 2012. On October 4, 2013 OWCP granted appellant a schedule award for an additional one percent impairment of the left upper extremity based on the September 26, 2013 opinion of its medical adviser. It noted that he was previously awarded 12 percent total left upper extremity impairment under claim number xxxxxx989 and its medical adviser opined that appellant was entitled to 13 percent left upper extremity. By decision dated February 24, 2014, an OWCP hearing representative affirmed the October 4, 2013 decision.

In a May 30, 2013 report and September 13, 2013 addendum, Dr. Fritzhand utilized the A.M.A., *Guides* and the range of motion method to provide an impairment rating for the left upper extremity. He determined that appellant had 17 percent left upper extremity impairment. This was comprised of 35 percent digit impairment which equaled an upper extremity impairment of 13 percent and 5 percent left upper extremity impairment from epicondylitis. The A.M.A., *Guides* provides that, under specific circumstances, range of motion may be selected as an alternative approach in rating upper extremity impairment and cautions that an impairment rating that is calculated using range of motion stands alone and may not be combined with a diagnosis-based impairment.[9] Pursuant to Table 15-2, the Digit Regional Grid, asterisks indicate that thumb impairments may be alternatively assessed using section 15.7, Range of Motion Impairment, if loss of motion is present.[10] Additionally, section 15.7a indicates that range of motion should be measured after a warm up, that the maximum range of motion should be measured at least three times and that the maximum measurement is used to determine range of motion measurement.[11] Dr. Fritzhand indicated that he had complied with these requirements and provided three individual measurements for each digit. Additionally, he utilized the range of motion grade modifiers, but found no adjustments were necessary.[12]

To determine the appropriate percentages of permanent impairment, OWCP referred Dr. Fritzhand's reports to its medical adviser. OWCP's medical adviser utilized Dr. Fritzhand's measurements and found appellant had combined left upper extremity impairment of 13 percent. He agreed with Dr. Fritzhand that appellant had 5 percent left upper extremity impairment from

[8] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence,* Chapter 2.808.7.a(2) (November 1998).

[9] A.M.A., *Guides* 390.

[10] *Id.* at 393-95.

[11] *Id.* at 464.

[12] *Id.* at 406, Table 15-7 and 477, Table 15-36.

epicondylitis. However, the medical adviser found that the final left thumb digit impairment calculated to 21 percent or 8 percent left upper extremity impairment as opposed to the 35 percent digit impairment or 13 percent left upper extremity impairment which Dr. Fritzhand assigned. He properly selected the highest of the three measurements for each range of motion test. Under Table 15-30, page 468, the medical adviser found appellant's thumb range of motion was 21 percent digit impairment. Under Table 15-30, he found three percent for 50 degrees IP flexion loss; one percent for zero percent IP extension loss, four percent for 30 degrees MCP flexion loss, zero percent for 0 degrees MCP extension (no loss), four percent for 5 cm adduction, five percent for 30 degrees abduction, and four percent for 4 degrees opposition. Under Table 15-35, the medical adviser found thumb range of motion was equal to grade modifier 2. Under Table 15-7, he found grade modifier functional history was 1 as opposed to Dr. Fritzhand's rating of 3 as there was no mention that appellant required modifications to perform self-care activities and thus a grade modifier of 2 secondary to the *Quick*DASH form as calculated by Dr. Fritzhand was not necessary. Under Table 15-35, the final adjustment between range of motion GMFH (2) -- range of motion grade modifier 1 equaled 1, which equated to 21 percent left thumb digit impairment. Under Table 16-12, the medical adviser converted the 21 percent left thumb impairment to 8 percent left upper extremity impairment. He combined the 8 percent left upper extremity impairment for the thumb and 5 percent impairment from the epicondylitis to find total 13 percent left upper extremity impairment. OWCP's medical adviser properly applied the appropriate portions of the A.M.A., *Guides* to Dr. Fritzhand's clinical findings. His opinion is sufficient to represent the weight of the medical evidence.[13]

There is no probative medical evidence to support a greater impairment than that awarded. As appellant previously received 12 percent total left upper extremity impairment and is now entitled to 13 percent left upper extremity impairment, OWCP properly awarded appellant an additional 1 percent left upper extremity impairment.[14]

On appeal, appellant challenges OWCP's award of additional one percent impairment to his left upper extremity, noting he still suffers residual symptoms. However, he has not submitted any probative medical evidence indicating that he has a greater impairment than that previously awarded.

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 sustain greater than 13 percent left upper extremity impairment.

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[13] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence,* Chapter 2.810.8(j) (September 2010).

[14] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims*, Developing and Evaluating Medical Evidence,* Chapter 2.808.7.a(2) (November 1998).

ORDER

IT IS HEREBY ORDERED THAT the February 24, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 13, 2014
Washington, DC

Patricia Howard Fitzgerald, Acting Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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