United States Department of Labor
Employees' Compensation Appeals Board

B.S., Appellant	)	
and	)	**Docket No. 13-2058**
	)	**Issued: March 11, 2014**
DEPARTMENT OF THE AIR FORCE, ROBINS AIR FORCE BASE, GA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On September 9, 2013 appellant filed a timely appeal from a July 5, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Appeals 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 more than 11 percent impairment of the left arm.

On appeal, appellant contends that his physician made a mistake on his report in that his surgery was for Dupuytren's release.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On May 3, 2000 appellant, then a 46-year-old sheet metal worker, sustained injury to his left hand while in the performance of duty. OWCP accepted his claim for a contusion of the left hand with Dupuytren's contracture. On July 18, 2000 Dr. Guy D. Foulkes, a Board-certified orthopedic surgeon, performed a subtotal palmar fasciectomy on appellant's left hand to treat his left Dupuytren's disease. On December 11, 2001 OWCP accepted appellant's claim for left contracted palmar fascia.

On January 7, 2002 OWCP granted a schedule award for an 11 percent impairment to appellant's left arm. This impairment rating was based on the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (1993) (A.M.A., *Guides*). OWCP denied appellant's request for reconsideration on January 21, 2003.

On September 9, 2010 Dr. Robert L. Howell, a Board-certified surgeon with additional Board-certifications in plastic surgery and surgery of the hand, performed an excision of Dupuytren's disease on appellant's left palm and long finger and palm and ring finger.

On October 30, 2012 appellant filed a claim for an additional schedule award. He submitted a July 24, 2012 report from Dr. Carlos Giron, a treating physician in pain medicine, who indicated that appellant's diagnosis was right hand *de Quervain's* tenosynovitis for which he underwent a *de Quervain's* tenosynovitis release by Dr. Howell. Dr. Giron found that appellant had a three percent impairment of his hand and a three percent impairment of his upper extremity. Applying Table 15-2 of the sixth edition of the A.M.A., *Guides*.[2] Dr. Giron noted that stenosing synovitis (*de Quervain's*) listed an impairment class for the diagnosed condition (CDX) of one with mid-range default of six percent digit impairment (one percent hand, one percent upper extremity). He noted no grade modifiers for Clinical Studies (GMCS), a grade 2 modifier for Functional History (GMFH) (decreased active range of motion and increased pain, unable to tolerate tool usage on a constant basis), and a grade 2 modifier for Physical Examination (GMPE) (decreased range of motion and strength resulting grade modifier of 2 pursuant to Table 15-31). Dr. Giron calculated GMFH - CDX (2-1) equaled 1; GMPE - CDX (2-1) equaled 1, and that GMCS was nonapplicable or 0. Adding these figures together (1+1-0), he found that appellant had an adjustment of 2 to the right of default grade C, resulting in a grade E, which equaled an eight percent digit impairment, or a three percent impairment of the hand or a three percent impairment of the upper extremity.

By letter dated November 13, 2012, OWCP informed appellant that Dr. Giron did not specify which hand was rated, but that it appeared it was the right hand. It noted that an injury to the right hand was not an accepted medical condition. Further, the diagnosis of *de Quervain's* tenosynovitis did not appear to be related to the accepted left contracted palmar fascia. OWCP requested that appellant submit additional medical evidence to establish greater impairment than the 11 percent previously compensated.

In a November 22, 2012 response, Brian Tharpe, a physical therapist, noted that an error had been made and that Dr. Giron had addressed appellant's left hand and upper extremity.

[2] A.M.A., *Guides* 392.

Although appellant received a previous impairment rating in 2002, he sustained a recurrent injury to his left hand, and that, "[t]he three [percent] impairment noted in the report should be considered an apportionment to his previous rating in 2002. Therefore, we stand by our rating of three [percent] left upper extremity impairment." On December 20, 2012 OWCP received a corrected copy of Dr. Giron's July 24, 2012 rating. Dr. Giron advised that appellant had left hand *de Quervain's* tenosynovitis and noted that the impairment rating was for three percent of the left hand or three percent of the left upper extremity.

On December 26, 2012 Dr. H.P. Hogshead, a medical adviser, reviewed the prior 11 percent impairment rating. The claim was accepted for a Dupuytren's contracture of the left hand for which surgery was performed and the 2002 schedule award was granted. Dr. Hogshead noted that appellant recently developed a *de Quervain's* stenosing tenosynovitis of the first dorsal compartment of the left wrist extensors. He stated that appellant's accepted condition did not include *de Quervain's* tendinitis. Dr. Hogshead noted that *de Quervain's* disease was an entirely different entity than Dupuytren's contracture and had nothing in common. He concluded that no additional impairment rating was appropriate.

By decision dated January 11, 2013, OWCP denied appellant's claim for an additional schedule award. It found that the *de Quervain's* tendinitis rated by Dr. Giron was not an accepted condition.

In reports dated December 20, 2012 through May 15, 2013, Dr. Giron listed his impression as left hand contusion; left hand palmer contractures; and left upper extremity complex regional pain syndrome/reflex sympathetic dystrophy. He also noted Dupuytren's contractures in both hands. In a September 22, 2010 note, Dr. Howell advised that appellant had Dupuytren's disease in his left palm as well as Dupuytren's disease with contracture to his left finger, for which he underwent surgery on September 9, 2010. On February 12, 2013 Mr. Tharpe stated that his original report did not address the Dupuytren's contracture or surgical releases. Based on appellant's limited use of hands, the three percent impairment rating was considered an apportionment to the previous rating in 2002.

On April 18, 2013 appellant requested reconsideration contending that there was a misunderstanding on his evaluation in that the examiner addressed the wrong surgery in the report. He stated that his surgery was for a Dupuytren's release performed by Dr. Howell.

On June 3, 2013 Dr. Hogshead reviewed the medical record and noted that the February 12, 2013 letter of Mr. Tharpe suggested a typographical error that referred to *de Quervain's* rather than Dupuytren's contracture. Dr. Hogshead stated that the therapist was confusing *de Quervain's* with Dupuytren's disease. He reiterated that *de Quervain's* disease was an entirely different entity than a Dupuytren's contracture and had nothing in common. As *de Quervain's* was not an accepted condition an impairment rating for *de Quervain's* was not related to the accepted Dupuytren's disease.

In a July 5, 2013 decision, OWCP denied modification of the January 11, 2013 decision.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations[3] set forth the number of weeks of compensation payable to employee's sustaining permanent impairment from loss or loss of use, of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of OWCP.[4] 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.[5] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[6]

The sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.[7] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[8] The sixth edition of the A.M.A., *Guides* also provides that range of motion may be selected as an alternative approach in rating impairment under certain circumstances. A rating that is calculated using range of motion may not be combined with a diagnosis-based impairment and stands alone as a rating.[9]

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*.[10]

ANALYSIS

OWCP accepted appellant's claim for a contusion of the left hand with Dupuytren's contracture and left contracted palmar fascia. On July 18, 2000 Dr. Foulkes performed a subtotal palmar fasciectomy on appellant's left hand to treat the left Dupuytren's disease. On January 7, 2002 OWCP granted appellant a schedule award for 11 percent impairment of his left arm.

[3] 20 C.F.R. § 10.404.

[4] *Linda R. Sherman*, 56 ECAB 127 (2004); *Daniel C. Goings*, 37 ECAB 781 (1986).

[5] *Ronald R. Kraynak*, 53 ECAB 130 (2001).

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

[7] A.M.A., *Guides* 494-531.

[8] *Id.* at 521.

[9] *L.B.*, Docket No. 12-910 (issued October 5, 2012).

[10] Federal (FECA) Procedure Manual, *supra* note 6 at Chapter 2.808.6(d) (August 2002).

Appellant had additional surgery on September 9, 2010, when Dr. Howell performed an excision of Dupuytren's disease in appellant's palm and long finger and palm and right finger.

Appellant requested an additional schedule award and submitted the July 24, 2012 report of Dr. Giron, who rated a three percent impairment of the hand and a three percent impairment of the upper extremity. The Board notes that the rating by Dr. Giron is of reduced probative value as the report listed appellant's right hand but the accepted conditions pertain to appellant's left hand. Furthermore, the rating was based on a diagnosis of *de Quervain's* disease, not the accepted conditions which included left Dupuytren's disease. When applying Table 15-2 of the A.M.A., *Guides,* Dr. Giron indicated that digital stenosing tenosynovitis, as listed in the A.M.A., *Guides,* was *de Quervain's,* and he rated this diagnosis, but it is not an accepted condition, as noted by Dr. Hogshead, who advised that *de Quervain's* was an entirely different entity than Dupuytren's contracture and the two conditions had nothing in common.

Dr. Giron subsequently provided a correction of the July 24, 2012 report and stated that the rating was for the left hand; however, the impairment rating was based on the diagnosis of *de Quervain's* tenosynovitis.

Mr. Tharpe stated that appellant actually had Dupuytren's contracture and that the surgical releases were performed to correct this condition. He also stated that the three percent impairment rating should be considered as an apportionment to the 2002 rating. As this report is not countersigned by a physician, it does not constitute probative medical evidence.[11]

The remaining evidence submitted on reconsideration is not probative on the issue of permanent impairment. Dr. Giron's reports noted continued treatment of appellant. Dr. Howell indicated that he treated appellant's Dupuytren's disease. Neither physician addressed the issue of permanent impairment based on the conditions accepted in this case.

The Board finds that appellant did not submit medical evidence to establish that he has greater than 11 percent impairment of his left arm.

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 has not established greater than 11 percent impairment of the left upper extremity, for which he received a schedule award.

[11] Evidence submitted by Mr. Tharpe, a "certified functional capacity evaluator" for a physical therapy practice is of no probative medical evidence. The Board has held that such persons as physician's assistants and physical therapists are not competent to render a medical opinion under FECA. *See David P. Sawchuk,* 57 ECAB 316 (2006) (lay individual such as physician's assistants, nurses and physical therapists are not competent to render a medical opinion under FECA); 5 U.S.C. § 8101(2) (this subsection defines a "physician as surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by State law).

ORDER

IT IS HEREBY ORDERED THAT the July 5, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 11, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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