United States Department of Labor
Employees' Compensation Appeals Board

F.C., Appellant	)	
and	)	**Docket No. 14-2053**
	)	**Issued: March 9, 2017**
U.S. POSTAL SERVICE, VEHICLE MAINTENANCE FACILITY, Lancaster, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On September 29, 2014 appellant, through counsel, filed a timely appeal from a July 7, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (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 greater than nine percent permanent impairment of the right upper extremity, for which he received schedule awards.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

OWCP accepted that on September 23, 2009 appellant, then a 52-year-old automotive technician, sustained the traumatic amputation of the tip of the distal phalanx of the right index finger when an automotive strut slipped, crushing his fingertip. He received treatment in a hospital emergency room immediately following the injury. Dr. Carl M. Adolph, Jr., an attending Board-certified orthopedic surgeon, diagnosed a degloving injury over the distal phalanx of the right index finger. He performed surgery on September 23, 2009 to debride the exposed bone and move soft tissue from the dorsal to volar aspect of the finger to achieve wound closure. Appellant returned to light-duty work in October 2009.

On August 5, 2010 Dr. Adolph performed a revised amputation of the distal phalanx of the right index finger, with excision and ablation of the nail bed.[3] OWCP approved the procedure.

On July 11, 2011 appellant filed a claim for a schedule award (Form CA-7). In a July 19, 2011 letter, OWCP advised him of the type of evidence needed to establish his claim.

In response, appellant submitted an August 2, 2011 evaluation of his right hand, performed by a physical therapist, who found range of motion for all digits of the right hand within normal limits, diminished light touch in the right median nerve distribution on Semmes-Weinstein monofilament testing, and impaired pinch strength due to pain. The therapist noted that appellant had returned to full duty as an automotive mechanic.

Appellant also provided an August 4, 2011 report from Dr. Adolph, reviewing the August 2, 2011 evaluation. Dr. Adolph opined that, based on the findings presented by the physical therapist, appellant had attained maximum medical improvement (MMI). On examination of the right hand, he found an essentially normal range of motion of the index finger, tenderness, and hypersensitivity of the index finger tip, diminished light touch sensation in the median nerve distribution with a reaction at 3.61 mgs on Semmes-Weinstein monofilament testing, diminished grip strength, and an inability to perform fine manipulation or pinching with the thumb and right index finger due to pain. Referring generally to an unspecified edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*), Dr. Adolph assessed 45 percent permanent impairment of the right index finger.

By decision dated November 3, 2011, OWCP denied appellant's schedule award claim because the medical evidence of record failed to establish ratable permanent impairment of a scheduled member of the body.

On October 22, 2012 counsel requested reconsideration. He asserted that Dr. Adolph's assessment of 45 percent impairment of the right index finger established a permanent impairment of a scheduled member. Counsel submitted copies of the August 2, 2011 physical therapist's evaluation and Dr. Adolph's August 4, 2011 report, both already of record.

On November 6, 2012 OWCP requested that its medical adviser provide an impairment rating. In a November 7, 2012 report, the medical adviser reviewed the medical record. He

[3] Appellant participated in physical therapy in October and November 2009.

noted that Dr. Adolph did not specify the length of the remaining distal phalanx following the August 5, 2010 revised amputation. The medical adviser also noted that he could not determine impairment due to sensory loss as two-point discrimination testing was not documented. He recommended that OWCP request clarification from Dr. Adolph.

In a November 27, 2012 letter, OWCP requested that Dr. Adolph clarify his impairment rating and provide documentation of two-point discrimination testing. Dr. Adolph's secretary contacted appellant three times to request that he make an appointment.[4] Appellant did not respond to these requests as of February 1, 2013.

By decision dated February 1, 2013, OWCP denied modification because the additional evidence submitted failed to establish that appellant sustained ratable permanent impairment of a scheduled member. It noted that Dr. Adolph was unable to clarify his opinion as appellant did not make an appointment for a follow-up examination.

On February 28, 2013 counsel requested reconsideration. He submitted a December 31, 2012 report from Dr. Arthur F. Becan, Jr., an attending orthopedic surgeon. Counsel asserted that Dr. Becan's opinion established 14 percent impairment of the right upper extremity. In his report, Dr. Becan reviewed the medical record and found that appellant had attained MMI. Appellant completed a *Quick*DASH questionnaire which scored at 65 percent permanent impairment of the right upper extremity. He noted difficulties with writing and other activities requiring pincer grasp, lifting, or fine manipulation with the right hand. On examination, Dr. Becan noted "an amputation just distal to the distal interphalangeal joint of the right index finger," with "tenderness to palpation at the distal interphalangeal joint and over the tip of the right index finger." He found flexion of the proximal interphalangeal joint at 80/100 degrees, with a full range of motion of all other joints of the right index finger. On Semmes-Weinstein monofilament testing, Dr. Becan observed a 6.6 mg sensitivity reading over the stump of the right index finger, compared to 3.6 mg in the left index finger. Two-point discrimination testing was 12 millimeters (mm) over the stump of the right index finger and four mm over the left index finger. Dr. Becan also noted three kilograms (kg) pinch key strength on the right versus 10 kg on the left. Referring to the sixth edition of the A.M.A., *Guides*, he assessed 40 percent impairment of the right index finger according to Figure 15-12[5] finger for "amputation distal to distal interphalangeal joint," 21 percent impairment of the digit under Table 15-31[6] for flexion of the proximal interphalangeal joint limited to 80 degrees, 45 percent impairment of the digit according to Table 15-31 for ankylosis of the distal interphalangeal joint at 30 degrees, and five percent impairment of the digit under Figure 15-4[7] and Table 15-17[8] for partial transverse sensory loss of both digital nerves over 20 percent of the finger length. Dr. Becan combined

[4] Appellant retired from the employing establishment effective January 31, 2013.

[5] Figure 15-12, page 458 is entitled "Digit Impairment for Finger Amputation at Various Levels."

[6] Table 15-31, page 470 is entitled "Finger Range of Motion."

[7] Figure 15-4, page 426 is entitled "Digit Impairment due to Thumb Amputation at Various Lengths (top scale) or Total Transverse Sensory Loss (bottom scale)." Page 426 also contains Figure 15-5, entitled "Digit Impairments due to Finger Amputation at Various Lengths (top scale) or Total Transverse Sensory Loss (bottom scale)."

[8] Table 15-17, page 427 is entitled "Digit Impairment for Transverse and Longitudinal Sensory Losses in *Index, Middle,* and *Ring Fingers Based on Percent of Digital Length Involved*." (Emphasis in original).

these percentages to equal 75 percent permanent impairment of the right index finger or 14 percent permanent impairment of the right upper extremity.

On March 5, 2013 OWCP requested that its medical adviser provide an updated impairment rating. In a March 6, 2013 report, the medical adviser reviewed the record as requested. He found 40 percent impairment of the right index finger according to Table 15-5 due to amputation of the right index finger just distal to the distal interphalangeal joint, and 5 percent impairment according to Table 15-17 due to sensory loss. The medical adviser discounted Dr. Becan's observation of ankylosis as inconsistent with appellant's maximum effort as observed by Dr. Adolph on August 4, 2011. Using the Combined Values Chart, the medical adviser combined the 40 and 5 percent impairments and determined that this equated to 4 percent impairment of the right upper extremity.

By decision dated March 21, 2013, OWCP vacated its February 1, 2013 decision, finding that Dr. Becan's opinion, as reviewed by the medical adviser, established appellant's four percent permanent impairment of the right arm, warranting a schedule award.

By decision dated March 26, 2013, OWCP granted appellant a schedule award for four percent impairment of the right upper extremity. The period of the award ran from December 31, 2012 to March 28, 2013.

In an April 2, 2013 letter, counsel requested an oral hearing. By decision dated and finalized June 24, 2013, an OWCP hearing representative found the case not in posture for decision and set aside the March 26, 2013 schedule award determination. She directed OWCP to select a second opinion specialist to perform an examination and impairment rating. The hearing representative noted that the discrepancy between Dr. Adolph's findings of full range of motion in the right index finger and Dr. Becan's observation of ankylosis in the distal interphalangeal joint required clarification. Additionally, she noted that the medical adviser did not explain his rationale for extending the right index finger impairment into the right arm.

On September 5, 2013 OWCP obtained a second opinion from Dr. Stuart J. Gordon, a Board-certified orthopedic surgeon. Appellant related difficulties with holding small objects, writing, typing, zipping, and buttoning. His right index finger was sensitive to cold. Dr. Gordon noted that appellant declined to add additional history. He concurred with Dr. Becan that appellant attained MMI as of December 31, 2012. On examination, Dr. Gordon found that appellant "essentially ha[d] an amputation at the DIP [distal interphalangeal] joint," with a "small component of soft tissue and bone distal to the DIP joint" and a small component of residual nail. He noted intact sensation at the fingertip with hypersensitivity to palpation, full flexion and extension through the residual metacarpophalangeal and proximal interphalangeal joints, and a "[h]alf grade of grip weakness." Dr. Gordon diagnosed "[s]tatus post right index finger partial amputation, just distal to the distal interphalangeal [joint], functioning as a distal interphalangeal amputation level." Referring to Figure 15-12 of the sixth edition of the A.M.A., *Guides*, he found 40 percent permanent impairment of the right index finger due to the amputation level. Dr. Gordon explained however, that the diagnosis-based impairment (DBI) rating methodology under Table 15-29[9] was preferable in appellant's case. He assigned a default eight percent impairment of the right upper extremity based on a grade 1 Class of Diagnosis (CDX) DBI due to the amputation level. He assigned a grade modifier for Functional History

[9] Table 15-29, page 460 of the A.M.A., *Guides* is entitled "Amputation Impairment."

(GMFH) of 2, a grade modifier for findings on Physical Examination (GMPE) of 1, and a grade modifier for Clinical Studies (GMCS) of 1. Applying the net adjustment formula of (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), or (2-1) + (1-1) + (1-1), Dr. Gordon calculated an adjustment of +1, raising the default grade of C upward to D. This equaled nine percent permanent impairment of the right upper extremity. On September 23, 2013 the medical adviser concurred with Dr. Gordon's impairment rating and methodology.

By decision dated October 23, 2013, OWCP issued appellant a schedule award for nine percent permanent impairment of the right upper extremity. It noted that as he previously received a schedule award for four percent impairment of the right upper extremity, he was due an additional five percent.

In an October 29, 2013 letter, counsel requested an oral hearing, held April 14, 2014. At the hearing, appellant contended that Dr. Gordon performed only a cursory examination. He described ongoing difficulties with fine motor activity. Counsel contended that Dr. Gordon's opinion was insufficient to represent the weight of the medical evidence as he did not administer a *Quick*DASH questionnaire, perform Semmes-Weinstein monofilament testing, or provide measurements for range of motion testing. He noted that Dr. Becan conducted appropriate testing and provided measurements to substantiate his findings. Counsel requested that OWCP refer appellant to a new second opinion examiner.

By decision dated and finalized July 7, 2014, the hearing representative affirmed the October 23, 2013 schedule award determination. She found that Dr. Gordon provided sufficient medical rationale supporting his assessment of nine percent right upper extremity impairment according to the A.M.A., *Guides*. The hearing representative further found that there was no medical evidence of record establishing a greater percentage of permanent impairment.

LEGAL PRECEDENT

Section 8149 of FECA delegates to the Secretary of Labor the authority to prescribe rules and regulations for the administration and enforcement of FECA. The Secretary of Labor has vested the authority to implement the FECA program with the Director of OWCP.[10] Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions, and organs of the body.[11] FECA, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the American Medical Association, *Guides to the Evaluation of Permanent Impairment* as the appropriate standard for evaluating schedule losses.[12]

The sixth edition of the A.M.A., *Guides* was first printed in 2008. Within months of the initial printing, the A.M.A. issued a 52-page document entitled "Clarifications and Corrections,

[10] *See* 20 C.F.R. §§ 1.1-1.4.

[11] For a complete loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1).

[12] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

Sixth Edition, *Guides to the Evaluation of Permanent Impairment.*" The document included various changes to the original text, intended to serve as an erratum/supplement to the first printing of the A.M.A., *Guides*. In April 2009, these changes were formally incorporated into the second printing of the sixth edition.

As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[13] 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.[14]

ANALYSIS

The issue on appeal is whether appellant has established that he sustained greater than nine percent impairment of the right upper extremity, for which he received schedule awards.

The Board finds that this case is not in posture for decision.

The Board has found that OWCP has inconsistently applied Chapter 15 of the sixth edition of the A.M.A., *Guides* when granting schedule awards for upper extremity claims. No consistent interpretation has been followed regarding the proper use of the DBI or the range of motion methodology when assessing the extent of permanent impairment for schedule award purposes.[15] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[16] In *T.H.*, the Board concluded that OWCP physicians are at odds over the proper methodology for rating upper extremity impairment, having observed attending physicians, evaluating physicians, second opinion physicians, impartial medical examiners, and district medical advisers use both DBI and range of motion methodologies interchangeably without any consistent basis. Furthermore, the Board has observed that physicians interchangeably cite to language in the first printing or the second printing when justifying use of either range of motion or DBI methodology. Because OWCP's own physicians are inconsistent in the application of the A.M.A., *Guides*, the Board finds that OWCP can no longer ensure consistent results and equal justice under the law for all claimants.[17]

In light of the conflicting interpretation by OWCP of the sixth edition with respect to upper extremity impairment ratings, it is incumbent upon OWCP, through its implementing regulations and/or internal procedures, to establish a consistent method for rating upper extremity impairment. In order to ensure consistent results and equal justice under the law for cases involving upper extremity impairment, the Board will set aside the July 7, 2014 decision. Following OWCP's development of a consistent method for calculating permanent impairment for upper extremities to be applied uniformly, and such other development as may be deemed

[13] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims,* Chapter 2.808.6a (February 2013); Part 3 -- Medical, *Schedule Awards,* Chapter 3.700, Exhibit 1 (January 2010).

[14] *Isidoro Rivera*, 12 ECAB 348 (1961).

[15] *T.H.*, Docket No. 14-0943 (issued November 25, 2016).

[16] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[17] *Supra* note 15.

necessary, OWCP shall issue a *de novo* decision on appellant's claim for an upper extremity schedule award.

CONCLUSION

The Board finds this case not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the July 7, 2014 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: March 9, 2017
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

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