United States Department of Labor
Employees' Compensation Appeals Board

D.K., Appellant	)	
	)	
and	)	**Docket No. 18-0135**
	)	**Issued: August 20, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Bakersfield, CA, Employer	)	

Appearances:
Appellant, pro se
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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On October 24, 2017 appellant filed a timely appeal from an August 29, 2017 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 to consider the merits of the case.[2]

ISSUES

The issues are: (1) whether appellant has established more than two percent permanent impairment of his right lower extremity for which he previously received schedule award compensation; and (2) whether appellant has established more than one percent permanent

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that following the August 29, 2017 decision OWCP received additional evidence in this claim. However, the Board's jurisdiction is limited to the evidence that was in the record at the time OWCP issued its final decision. Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *See* 20 C.F.R. § 501.2(c)(1); *M.B.*, Docket No. 09-0176 (issued September 23, 2009); *J.T.*, 59 ECAB 293 (2008).

impairment of his right upper extremity for which he previously received schedule award compensation.

FACTUAL HISTORY

On January 22, 2007 appellant filed an occupational disease claim (Form CA-2) alleging that he developed pain in his right shoulder, right elbow, right wrist, as well as numbness and pain in his right hand. He attributed his upper extremity conditions to his job duties, including operating a motor vehicle, delivering mail, lifting trays of mail, and casing mail. OWCP assigned the claim File No. xxxxxx227 and, on March 8, 2007, accepted it for sprain of the right shoulder and upper arm. Appellant returned to modified work on May 23, 2008. On November 7, 2008 OWCP expanded acceptance of the claim to include right shoulder calcifying tendinitis and right trigger thumb. It further expanded acceptance of the claim, on February 11, 2010, to include right knee tear. On March 30, 2011 appellant underwent a surgical right thumb A1 pulley release.

On November 4, 2014 appellant filed a traumatic injury claim (Form CA-1) alleging that on October 31, 2014 his right knee collapsed, he lost his balance, missing a step, and sprained his left ankle. OWCP assigned that claim OWCP File No. xxxxxx240 and accepted it for sprain of the right knee and leg, lumbar sprain, sprain of the left ankle, and contusion of the left hip.[3]

In a series of reports dated beginning on October 10, 2014, Dr. Kamal Eldrageely, a physiatrist, noted that appellant complained of right knee pain. He indicated that appellant had a prior injury to his patella and had undergone knee surgery.

In a report dated November 24, 2014, Dr. Eldrageely reviewed appellant's right knee magnetic resonance imaging (MRI) scan and found a severe thinning and fraying of the patellar articular cartilage. He diagnosed right knee strain.

On January 29, 2015 Dr. Ronald Glousman, a Board-certified orthopedic surgeon, performed a diagnostic arthroscopy, partial medial meniscectomy, synovectomy, and chondroplasty on appellant's right knee. On July 13, 2015 OWCP expanded the acceptance of appellant's claim to include late effect of right tendon injury to the right thumb and tear of the medial meniscus of the right knee.

Through a letter dated July 21, 2015, OWCP referred appellant, a statement of accepted facts (SOAF),[4] and a list of questions for a second opinion evaluation with Dr. Ernest B. Miller, a Board-certified orthopedic surgeon. In his August 13, 2015 report, Dr. Miller diagnosed superior labral tear of the right shoulder with full range of motion and excellent strength. He also found that appellant had full range of motion of his right thumb following the trigger thumb release, and

[3] OWCP File Nos. xxxxxx227 and xxxxxx240 have been administratively combined, with File No. xxxxxx227 serving as the master file.

[4] The July 13, 2015 SOAF indicated that appellant had undergone left shoulder surgery on January 29, 2015 as well as his documented right knee surgery on that date. OWCP advised Dr. Miller of the error and received a revised report which omitted references to the left shoulder procedure.

that he had full range of motion of his right knee following the partial medial meniscectomy with no swelling or instability.

Appellant retired from the employing establishment on July 31, 2015.

Dr. Richard E. Sall, a Board-certified physiatrist, completed a report on November 19, 2015 and noted loss of range of motion for appellant's right thumb and right shoulder, as well as minor discomfort in his right knee. He opined that appellant had reached maximum medical improvement (MMI).

On February 3, 2016 Dr. Sall completed an impairment rating for schedule award purposes. He evaluated appellant's percentage of permanent impairment in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[5] Dr. Sall determined that appellant reached MMI on February 3, 2016. He noted appellant's history of injury on January 2, 2003, as well as appellant's October 31, 2014 work injury which resulted in right knee strain, lumbar strain, left ankle strain, and contusion to the hip. Dr. Sall provided range of motion figures for appellant's extremities including his right shoulder as: 130 degrees of flexion, 30 degrees of extension, 26 degrees of adduction, 130 degrees of abduction, 21 degrees of internal rotation, and 50 degrees of external rotation. Appellant's right thumb exhibited: 60 degrees of metacarpophalangeal (MP) joint flexion, 35 degrees of MP joint extension, 50 degrees of radial abduction; and 3 degrees of carpometacarpal (CMC) joint adduction. The right knee MRI scan on November 19, 2014 demonstrated a tear of the posterior horn of the medial meniscus, severe thinning and fraying of the patella articular cartilage, and minimal marginal osteophytes of the patella. Dr. Sall diagnosed partial medial meniscectomy of the right knee, surgical release of the right trigger thumb, and healed calcific tendinitis of the right shoulder.

On July 18, 2016 appellant filed a claim for a schedule award (Form CA-7).

On August 2, 2016 OWCP requested that Dr. Sall provide an opinion on the extent of appellant's percentage of permanent impairment for schedule award purposes utilizing the sixth edition of A.M.A., *Guides*.[6]

In a supplemental report dated September 3, 2016, Dr. Sall evaluated appellant's percentage of permanent impairment. He found that appellant had no permanent impairment of his right thumb, as his digital stenosing tenosynovitis was corrected by surgery.[7] Dr. Sall determined, using the diagnosis-based impairment (DBI) methodology, that appellant had one percent permanent impairment of his right shoulder due to class 1 functional history, as well as mild physical examination and functional history grade modifiers which are consistent with grade

[5] A.M.A., *Guides* (5th ed. 2001).

[6] A.M.A., *Guides* (6th ed. 2009).

[7] *Id*. at 392, Table 15-2.

C.[8] He evaluated appellant's right knee permanent impairment as a meniscal injury, grade C, with a two percent permanent impairment rating.[9]

In a report dated March 16, 2017, OWCP's medical adviser, Dr. Herbert White, Jr., a physician Board-certified in occupational medicine, reviewed Dr. Sall's reports and found that appellant reached MMI on February 3, 2016. He calculated two percent permanent impairment of appellant's right lower extremity due to his partial medial meniscectomy.[10] Dr. White, also utilizing the DBI methodology, determined that appellant had grade 1 modifiers for functional history and physical evaluation. He applied the net adjustment formula and determined that appellant's default impairment at class 1, grade C was two percent impairment of the right lower extremity.

In regard to appellant's right shoulder, Dr. White found that the diagnosis was shoulder tendinitis and class 1 diagnosis.[11] He determined that appellant had grade 1 modifiers for functional history and physical evaluation. Dr. White applied the net adjustment formula and reached an impairment rating of one percent of the right upper extremity. He also agreed with Dr. Sall's finding that appellant had no permanent impairment of his right thumb.

On April 24, 2017 OWCP requested a supplemental report from Dr. Sall addressing whether appellant's permanent impairment rating was based on the whole person or on specific affected, scheduled members.

In a report dated May 7, 2017, Dr. Sall noted that appellant's impairment rating was based on permanent impairment of the specific effected members and not the whole person.

In a report dated July 14, 2017, Dr. Sall listed appellant's range of motion (ROM) in his left lower extremity. He completed a report on July 26, 2017 and found that appellant had reached MMI. Dr. Sall noted appellant's history of injury on October 31, 2014 including tenderness over the right knee. He opined that appellant had recovered following right knee surgery, but continued to have pain in the left ankle, hip, and back. Dr. Sall's diagnoses included status post partial medial meniscectomy of the right knee, arthroscopically healed, chronic lumbar strain, chronic trochanteric bursitis of the left hip, severe sprain of the left ankle with osteochondral lesion of the medial talar dome, and split peroneus brevis tendon of the left ankle. He provided appellant's impairment ratings in accordance with the sixth edition of the A.M.A., *Guides*. Dr. Sall found one percent permanent impairment of the whole person due to the partial medial meniscectomy of the right knee.

By decision dated August 29, 2017, OWCP granted appellant schedule award compensation for two percent permanent impairment of his right lower extremity and one percent permanent impairment of his right upper extremity. It found that appellant should receive

[8] *Id*. at 402, Table 15-5.

[9] *Id*. at 509, Table 16-3.

[10] *Id.*

[11] A.M.A., *Guides* 402, Table 15-5.

compensation for 5.76 weeks or 40.32 days for two percent permanent impairment of his right lower extremity and 3.12 weeks or 21.84 days for one percent permanent impairment of his right upper extremity, for a total of 8.88 weeks or 62.16 days of compensation for both permanent impairments in the amount of $7,100.35.[12]

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA[13] and its implementing regulations[14] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss or loss of use, of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*, published in 2009.[15]

In determining impairment for the lower extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the lower extremity to be rated. With respect to the knee, reference is made to Table 16-3 (Knee Regional Grid) beginning on page 509.[16] After the Class of Diagnosis (CDX) is determined from the Knee 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) + (GMPE-CDX) + (GMCS-CDX).[17] 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.[18]

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[12] On April 9, 2018 OWCP issued a decision denying appellant's claim for a schedule award under File No. xxxxxx240. Appellant subsequently requested a hearing and OWCP's Branch of Hearings and Review issued a decision on July 2018, which vacated the April 9, 2018 decision and remanded the case for further development of that issue. The Board and OWCP may not simultaneously have jurisdiction over the same issue. Because the April 9 and July 20, 2018 decisions were issued while the same issue was pending before the Board, those decisions are null and void. *Arlonia B. Taylor*, 44 ECAB 591, 597 (1993).

[13] 5 U.S.C. § 8107.

[14] 20 C.F.R. § 10.404.

[15] For decisions issued after May 1, 2009 OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, 6th ed. (2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[16] A.M.A., *Guides* 509, Table 16-3.

[17] *Id*. at 515-22.

[18] *Id*. at 23-28.

ANALYSIS -- ISSUE 1

The Board finds that appellant has not established more than two percent permanent impairment of his right lower extremity for which he previously received schedule award compensation.

OWCP accepted that appellant sustained a right knee sprain and medial meniscal tear with resulting surgery. Appellant's physician, Dr. Sall, and OWCP's medical adviser, Dr. White, agreed that appellant had two percent permanent impairment of his right lower extremity due to his medial meniscal tear under the DBI methodology. The A.M.A., *Guides* provide that a partial medial meniscectomy is a class 1 impairment with a default grade C impairment value of two percent of the lower extremity.[19] Dr. White determined that appellant had grade 1 modifiers for functional history and physical examination. He applied the net adjustment formula and determined that appellant's default impairment at class 1, grade C was two percent permanent impairment of the right lower extremity. OWCP properly found that the medical evidence does not establish more than two percent impairment of appellant's right lower extremity for which he previously received a schedule award.

On appeal appellant argues that he should receive a longer period of compensation due to the two percent impairment of his right lower extremity. For a complete loss of use of a leg, an employee shall receive 288 weeks of compensation.[20] As appellant has 2 percent permanent impairment of his right lower extremity, he is entitled to 2 percent of 288 weeks or 5.76 weeks of compensation as determined by OWCP. Appellant has not submitted any medical evidence establishing that he has more than two percent permanent impairment of his right lower extremity.

Appellant may request a schedule award or increased schedule award at any time based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

LEGAL PRECEDENT -- ISSUE 2

The sixth edition requires, for upper extremity permanent impairment ratings, identifying the impairment CDX condition, which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[21] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

The A.M.A., *Guides* also provide that the ROM impairment method is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other diagnosis-based sections are applicable.[22] If ROM is used as a stand-alone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are

[19] *Id*. at 509, Table 16-3.

[20] 5 U.S.C. § 8107(c)(2).

[21] A.M.A., *Guides* 401-19.

[22] *Id.* at 461.

measured and added.[23] Adjustments for functional history may be made if the evaluator determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[24]

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology *versus* the ROM methodology for rating upper extremity impairments.[25] Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides in pertinent part:

> "As the [A.M.A.,] *Guides* caution that if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s).
>
> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify (1) the methodology used by the rating physician (*i.e.*, DBI or ROM) and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. If the [A.M.A.,] *Guides* allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used." (Emphasis in the original.)[26]
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> The Bulletin further advises:
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> "If the medical evidence of record is not sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence necessary to complete the rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence.
>
> "Upon receipt of such a report, and if the impairment evaluation was provided from the claimant's physician, the CE should write to the claimant advising of the medical evidence necessary to complete the impairment assessment and provide 30 days for submission. Any evidence received in response should then be routed back to the DMA for a final determination. Should no evidence be received within 30 days of the date of the CE's letter, the CE should proceed with a referral for a second opinion medical evaluation to obtain the medical evidence necessary to complete

[23] *Id*. at 473.

[24] *Id.* at 474.

[25] FECA Bulletin No. 17-06 (issued May 8, 2017).

[26] *Id.*

the rating. After receipt of the second opinion physician's evaluation, the CE should route that report to the DMA for a final determination."[27]

ANALYSIS -- ISSUE 2

The Board finds that this case is not in posture for decision regarding the rating of appellant's right upper extremity permanent impairment due to his accepted right shoulder and thumb conditions.

OWCP has accepted appellant's claim for sprain of the right shoulder and calcifying tendinitis of the right shoulder, as well as right trigger finger and right thumb tendon injury. In his February 3, 2016 report, Dr. Sall provided range of motion measurements for appellant's right shoulder as well as his right thumb, but he did not use the measurements to rate appellant's permanent impairment pursuant to the A.M.A., *Guides.* In his supplemental report dated September 3, 2016, Dr. Sall provided a right upper extremity impairment rating utilizing the DBI method. He concluded that appellant had one percent permanent impairment of the right shoulder and zero percent permanent impairment of the right trigger finger.

On March 16, 2017 OWCP's DMA reviewed Dr. Sall's DBI rating and agreed that appellant had one percent permanent impairment of his right shoulder and zero percent permanent impairment of his right trigger finger. As the A.M.A., *Guides* allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnoses in question, the method producing the higher rating should have been used. The DMA should also have rated appellant's permanent impairment using the stand-alone ROM methodology to determine whether there was a higher possible rating. If the medical evidence of record was insufficient for the DMA to render a rating on ROM methodology where allowed, the DMA should have advised as to the medical evidence necessary to complete the rating.

On remand OWCP shall obtain a supplemental report from the DMA, pursuant to FECA Bulletin 17-06. After such further development as deemed necessary OWCP shall issue a *de novo* decision regarding appellant's entitlement schedule award compensation for permanent impairment of his right upper extremity.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish more than two percent permanent impairment of his right lower extremity for which he previously received schedule award compensation. The Board further finds that this case is not in posture for decision with respect to the extent of appellant's right upper extremity permanent impairment.

[27] *Id.*

ORDER

IT IS HEREBY ORDERED THAT the August 29, 2017 decision of the Office of Workers' Compensation Programs is affirmed with respect to the schedule award for appellant's right lower extremity. The August 29, 2017 decision is set aside with respect to the schedule award for appellant's right upper extremity and the case is remanded to OWCP for action consistent with this decision.

Issued: August 20, 2018
Washington, DC

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

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board