United States Department of Labor
Employees' Compensation Appeals Board

C.W., Appellant	)	
and	)	**Docket No. 17-0791**
	)	**Issued: December 14, 2018**
DEPARTMENT OF THE NAVY, NAVAL EXPEDITIONARY MEDICAL SUPPORT, Williamsburg, VA, 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
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On February 28, 2017 appellant filed a timely appeal from a December 20, 2016 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.[2]

ISSUE

The issue is whether appellant has met her burden of proof to establish permanent impairment to a scheduled member, for schedule award purposes.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that appellant submitted additional evidence on appeal. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this evidence for the first time on appeal. *Id*.

FACTUAL HISTORY

On September 15, 2014 appellant, then a 53-year-old support service assistant, filed a traumatic injury claim (Form CA-1) alleging that on September 10, 2014, while leaving a work-related training session, she tripped on uneven pavement and fell bruising the top of her right hand and breaking her ring and little finger. OWCP accepted her claim for right little finger comminuted fracture or proximal interphalangeal (PIP) joint and left hand abrasion. It authorized surgeries that were performed on September 17 and December 19, 2014. Initial medical reports dated September 10, 2014 from Dr. Matt A. Uzer, a Board-certified internist specializing in emergency medicine, diagnosed closed phalanx fracture and abrasion of the left hand. An x-ray of the right hand of even date revealed acute fracture head of the fifth right proximal phalanx and lucent lesions within the fourth proximal phalanx.

On September 17, 2014 Dr. Nicholas A. Smerlis, a Board-certified orthopedist, performed an authorized open reduction of articular fracture involving the PIP joint with fixation. He diagnosed right little comminuted articular fracture involving the PIP joint. In reports dated September 19 to November 25, 2014, Dr. Smerlis noted that appellant had transitioned to nighttime splinting and therapy focused on range of motion on the ulnar aspect of the hand. X-rays of the finger dated November 25, 2014 revealed acceptable alignment of fracture and hardware without intervening complications. Dr. Smerlis recommended removal of hardware from the right little finger with extensor tenolysis and PIP joint capsulectomy. On December 19, 2014 he performed a capsulectomy of the right little PIP joint, tenolysis of the right little extensor tendon, and removal of hardware of the right little finger. Dr. Smerlis diagnosed right little articular fracture involving the PIP joint with retained hardware, PIP joint capsular adhesions, and extensor tendon adhesions. On February 13, 2015 he noted mild volar subluxation of the PIP joint by x-ray and opined that improvement in the PIP joint extension was not anticipated and would be accompanied by post-traumatic degenerative changes. Dr. Smerlis noted that there would be residual partial impairment.

Appellant underwent occupational therapy from September 23, 2014 to March 6, 2015.

A January 2, 2015 magnetic resonance imaging (MRI) scan of the right hand revealed extensive lobulated marrow replacing process from the base to the head of the right fourth proximal phalanx, and postoperative changes seen in the region of the fifth PIP joint related to previous open reduction internal fixation and hardware removal.

Appellant was reexamined by Dr. Smerlis on April 10, 2015 who noted that she recovered grip strength and was gradually returning to full duty without restrictions. Dr. Smerlis diagnosed closed fracture of the middle or proximal phalanx of the hand, benign neoplasm of connective and other soft tissue of upper limb, and bone lesion. On May 8, 2015 he noted appellant's history of injury and diagnosed closed fracture of the middle or proximal phalanx or phalanges of the right hand. Dr. Smerlis noted that she was status post right articular fracture involving the PIP joint, status post open reduction internal fixation, subsequent removal and tenolysis/contracture. He advised that appellant had reached maximum medical improvement (MMI) without permanent restrictions. Dr. Smerlis opined that she had nine percent permanent impairment of her hand pursuant to the fifth edition of the American Medical Association, *Guides to the Evaluation of*

Permanent Impairment, (A.M.A., *Guides*).[3] He noted findings on examination of the right little finger "+20 (0%)/ 80 (6%) MCP [metacarpophalangeal], -75 (52%) / 95 (3%) PIP, -5 (1%) / 30 (21%) DIP [distal interphalangeal]." With regard to the right ring finger Dr. Smerlis noted findings of "+10 (3%) / 80 (6%) MCP, -25 (9%) / 105 (0%) PIP, 0 (0%)/55 (7%) DIP." He noted "Grip 96% 45/47, 71% 22/31, 65% 30/46, 49% 18/37." Dr. Smerlis opined that loss of range of motion for the right little finger yielded 68 percent digit impairment[4] which converted to 7 percent hand impairment, pursuant to Table 16-1 of the A.M.A., *Guides*. He further noted that loss of range of motion for the right finger yielded 22 percent digit impairment[5] which converted to 2 percent hand impairment, pursuant to Table 16-1 of the A.M.A., *Guides*. Dr. Smerlis opined that appellant had nine percent impairment rating of the right hand.

In a report dated January 15, 2016, Dr. Smerlis treated appellant for increasing right hand pain radiating to the wrist. He noted a history of injury and diagnoses. Dr. Smerlis noted findings on examination of the right little finger of healed surgical incision without hypertrophy or tenderness, no gross laxity to radial or ulnar stress, moderate tenderness at the PIP joint, no atrophy, intact sensory and motor function in the median, radial and ulnar nerves. He noted range of motion for the right little finger of "+20 (+20)/80 (80) MCP, -80 (-75)/95 (95) PIP, -5 (-5) / 30 (30) DIP." Dr. Smerlis recommended symptomatic management including splinting, oral medications, topical medications therapy, injections, and trial compounding transdermal pain formulation.

On August 23, 2016 appellant filed a claim for a schedule award (Form CA-7).

On September 12, 2016 OWCP requested that appellant submit a detailed report from her treating physician which provided an impairment evaluation pursuant to the sixth edition of the A.M.A., *Guides*.[6] It specifically requested an opinion as to whether she had reached MMI, a diagnosis upon which the impairment was based including surgery and a detailed description of objective and subjective complaints, a detailed description of any permanent impairment, a final rating of permanent impairment, and a discussion of the rationale for the calculation of impairment with references to the applicable criteria and tables in the A.M.A., *Guides*.

Appellant submitted reports from Dr. Smerlis dated September 15, 2014 to January 15, 2016 and a right hand MRI scan dated September 12, 2016, all previously of record.

On November 9, 2016 OWCP's medical adviser, reviewed the record, including Dr. Smerlis' May 8, 2015 report. He noted that an impairment rating for the diagnosis of an intra-articular proximal phalanx fracture of the right small finger could not be calculated because of a lack of information. The medical adviser requested a detailed history of appellant's current complaints including pain at rest and with activity, the ability to perform self-care activities,

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

[4] *Id.* at Figure 16-21, Figure 16-23, and Figure 16-25.

[5] *Id.*

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

physical findings including alignment of the phalanx fracture, valid finger range of motion measurements, and the most recent x-rays.

On November 15, 2016 OWCP requested that Dr. Smerlis submit a detailed report which provided an impairment evaluation pursuant to the sixth edition of the A.M.A., *Guides*.[7] It specifically requested an opinion including a detailed description of any permanent impairment, a final rating of permanent impairment, and a discussion of the rationale for the calculation of impairment with references to the applicable criteria and tables in the sixth edition of the A.M.A., *Guides*.

On December 2, 2016 Dr. Smerlis resubmitted his report dated May 8, 2015.

By decision dated December 20, 2016, OWCP denied appellant's claim for a schedule award because the evidence of record was insufficient to establish permanent impairment to a scheduled member due to her accepted work injury.

LEGAL PRECEDENT

The schedule award provision of FECA[8] and its implementing federal regulations,[9] 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[10] For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[11]

The sixth edition of 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).[12] Under the sixth edition, for upper extremity impairments the evaluator identifies the impairment class of diagnosis (CDX) condition, which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE), and clinical studies (GMCS).[13] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[14]

[7] *Id.*

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

[10] *Id.* at § 10.404(a).

[11] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[12] A.M.A., *Guides*, 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[13] *Id.* at 385-419.

[14] *Id.* at 411.

The grade modifiers are used on the net adjustment formula described above to calculate a net adjustment. The final impairment grade is determined by adjusting the grade up or down the default value C, by the calculated net adjustment.[15]

The Board has held that where the residuals of an injury to a member of the body specified in the schedule award provisions of FECA[16] extend into an adjoining area of a member also enumerated in the schedule, such as an injury of a finger into the hand, of a hand into the arm or of a foot into the leg, the schedule award should be made on the basis of the percentage loss of use of the larger member.[17]

ANALYSIS

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

In support of her claim for a schedule award appellant submitted a May 8, 2015 report from Dr. Smerlis who diagnosed closed fracture of the middle or proximal phalanx or phalanges of the right hand. Dr. Smerlis noted that she was status post right articular fracture involving the PIP joint, status post open reduction internal fixation, and subsequent removal and tenolysis/ contracture. He noted findings on examination and referenced the fifth edition of the A.M.A., *Guides* noting that loss of range of motion for the right little finger yielded 68 percent digit impairment[18] or 7 percent hand impairment under Table 16-1. Dr. Smerlis further found that loss of range of motion of the right finger yielded 22 percent digit impairment[19] or 2 percent hand impairment under Table 16-1.

In order to further develop the claim as to the nature and extent of permanent impairment, on November 9, 2016 OWCP's medical adviser reviewed Dr. Smerlis' report and noted that an impairment rating could not be calculated because of a lack of information. The district medical adviser (DMA) requested that an updated medical report be obtained from the attending physician to provide a detailed history of appellant's current complaints including pain at rest and with activity and the ability to perform self-care activities, physical findings including alignment of the phalanx fracture and valid finger range of motion measurements, and the most recent x-rays.

On November 15, 2016 OWCP requested that Dr. Smerlis submit a detailed report addressing the physical examination findings that the DMA had noted that he required to complete a rating of permanent impairment under the sixth edition of the A.M.A., *Guides*. On December 2, 2016 Dr. Smerlis merely resubmitted his report dated May 8, 2015, which had previously been

[15] *Id*. at 387.

[16] 5 U.S.C. § 8107.

[17] *Asline Johnson*, 42 ECAB 619 (1991); *Manuel Gonzales*, 34 ECAB 1022 (1983). *See supra* note 11 at Chapter 2.808.5(e) (February 2013).

[18] *Supra* note 4.

[19] *Supra* note 4.

found deficient by the DMA. Without further claim development, by decision dated December 20, 2016, OWCP denied appellant's schedule award claim.

Proceedings under FECA are not adversarial in nature, nor was OWCP a disinterested arbiter. While the claimant has the responsibility to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[20] It has the obligation to see that justice is done. Accordingly, once OWCP undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.[21]

OWCP's DMA reported that the physical findings reported by Dr. Smerlis were insufficiently detailed to calculate a rating of permanent impairment under the sixth edition of the A.M.A., *Guides*. Dr. Slutsky indicated that a permanent impairment rating could not be performed due to a "lack of information." However, the Board finds that Dr. Smerlis provided range of motion findings, but Dr. Slutsky provided no explanation as to the deficiencies in those findings in his medical report. The Board notes that OWCP procedures require that if the DMA believes that the impairment has not been correctly described by the claimant's physician or the second opinion examiner, the DMA should specify the missing information so that it can be requested.[22] Herein, the Board cannot discern the missing information necessary to complete an impairment evaluation. The case will accordingly be remanded to OWCP for further development. After such further development as is deemed necessary, and shall issue a *de novo* decision consistent with this decision.

CONCLUSION

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

[20] *R.B.*, Docket No. 08-1662 (issued December 18, 2008).

[21] *See P.D.*, Docket No. 15-1111 (issued December 7, 2015).

[22] *Supra* note 17 at Chapter 2.808.6(d) (February 2013); *see also id.* Chapter 2.808.6(f)(2)(c) (February 2013) (when OWCP's medical adviser believes that the permanent impairment has not been properly described, a new evaluation may be obtained).

ORDER

IT IS HEREBY ORDERED THAT the December 20, 2016 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this decision.

Issued: December 14, 2018
Washington, DC

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

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

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