United States Department of Labor
Employees' Compensation Appeals Board

F.V., Appellant	)	
and	)	**Docket No. 18-0427**
	)	**Issued: November 9, 2018**
PEACE CORPS VOLUNTEER SERVICES, La Paz, Honduras, 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 December 26, 2017 appellant filed a timely appeal from an October 26, 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 over the merits of the case.[2]

ISSUE

The issue is whether appellant has met his burden of proof to establish more than 13 percent permanent impairment of his right upper extremity, for which he previously received schedule award compensation.

[1] 5 U.S.C. § 8101 *et seq.*

[2] Appellant submitted additional evidence on appeal. However, "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

This case has previously been before the Board.[3] The facts as presented in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On March 24, 2011 appellant, then a 68-year-old Peace Corps volunteer, filed a traumatic injury claim (Form CA-1) alleging that on February 9, 2011 he injured his right arm when he fell down steps at his home in Honduras. OWCP accepted the claim for fracture of the right radius head, closed fracture of the olecranon process of the right ulna, contracture of elbow joint, and pain in joint, arm, and hand of the right upper extremity. After having surgery in Honduras and Panama, Dr. Douglas P. Hanel, a Board-certified orthopedic surgeon, performed additional right elbow surgery on June 1 and October 12, 2011 in Seattle, Washington.

By decision dated March 21, 2012, OWCP terminated appellant's wage-loss compensation, finding that he had no further disability due to his work injury. Following a request for reconsideration, by decision dated July 6, 2012, it denied modification of its prior decision.

Appellant filed a schedule award claim (Form CA-7) on July 27, 2012.

In a July 24, 2012 report, Dr. Honorio Claros Fortin, an orthopedic surgeon, noted appellant's physical examination findings of right elbow active flexion of 50 degrees, extension to 165 degrees, right wrist dorsiflexion of 55 degrees, left wrist dorsiflexion of 75 degrees, right volar flexion of 55 degrees, and left volar flexion of 80 degrees. There was no pronation or supination, and the fingers of the right and left hand had complete mobility and normal strength.

By development letter dated August 21, 2012, OWCP asked appellant to provide an impairment rating in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*).[4] It afforded him 30 days to submit the requested information. Appellant submitted no additional medical reports.

By decision dated September 26, 2012, OWCP denied appellant's schedule award claim. Following a request for reconsideration, by decision dated November 1, 2012, it denied modification of the September 26, 2012 decision.

In a November 1, 2012 letter, OWCP forwarded the medical evidence of record to Dr. Hanel and requested a permanent impairment evaluation in accordance with the sixth edition of the A.M.A., *Guides*. On January 14, 2013 Dr. Hanel indicated that appellant had been examined 15 months status post right elbow resection of heterotopic ossification with contracture release on October 12, 2011. He provided physical examination findings and advised that appellant's right shoulder range of motion was full, flexion-extension of the right elbow was 25 to 130 degrees, and appellant could pronate to 30 degrees and supinate to neutral. Sensation was noted as normal. Dr. Hanel indicated that arthritis of the ulnohumeral joint was continuing to worsen and that

[3] Docket No. 14-0986 (issued January 17, 2017).

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

appellant was at maximum medical improvement (MMI). He indicated that appellant would require a total elbow arthroplasty or arthrodesis in the future.

OWCP attempted to schedule a second opinion evaluation while appellant was stateside, but was unsuccessful. Appellant scheduled his own appointment with Dr. Brian D. Cameron, a Board-certified orthopedic surgeon, and OWCP authorized the visit. In his February 3, 2013 report, Dr. Cameron described the employment injury and subsequent medical treatment and noted appellant's complaint of persistent right elbow pain and a sense of weakness. He advised that physical examination demonstrated 30 degrees of flexion contracture to approximately 110 degrees with profound weakness in both pronation and supination due to ankylosis. Sensation was intact distally. Dr. Cameron diagnosed severe post-traumatic arthritis of the right elbow with associated ankylosis in supination, status post radial head prosthetic arthroplasty. He indicated that appellant had reached MMI and advised that at some point he would require a total elbow replacement. In accordance with the fifth edition of the A.M.A., *Guides*,[5] Dr. Cameron found a combined 53 percent right upper extremity permanent impairment.

On March 13, 2013 OWCP asked Dr. Cameron to provide an impairment rating in accordance with the sixth edition of the A.M.A., *Guides*. On June 10, 2013 Dr. Cameron advised that, in accordance with Table 15-33, elbow/forearm range of motion (ROM), appellant had a class 1 limitation of flexion to approximately 110 degrees, for 3 percent permanent impairment, 30 degrees lack of full extension for 2 percent permanent impairment, and 20 degrees of supination for 15 percent upper extremity impairment rating, for a combined right upper extremity permanent impairment of 20 percent.

On June 20, 2013 Dr. Morley Slutsky, an OWCP medical adviser Board-certified in occupational medicine, reviewed the medical record, including Dr. Cameron's June 10, 2013 report. Dr. Slutsky indicated that Dr. Cameron's ROM measurements were invalid because he did not follow instructions found in the A.M.A., *Guides*. He advised that appellant's most impairing diagnosis was radial head arthroplasty, complicated. Dr. Slutsky found that, utilizing the diagnosis-based impairment (DBI) method, under Table 15-4, Elbow Regional Grid, for this diagnosis, appellant had a class 1 impairment with a default value of 11 percent, and modifiers of 2 for functional history and 3 each for physical examination and clinical studies. After applying the net adjustment formula, he concluded that appellant had 13 percent right upper extremity permanent impairment, the maximum allowed for this diagnosis.

On July 18, 2013 OWCP forwarded Dr. Slutsky's evaluation to Dr. Cameron for review. On July 24, 2013 it notified appellant that it would not authorize another physician visit for an impairment evaluation.

Appellant submitted an August 13, 2013 report in which Dr. Charles N. Brooks, a Board-certified orthopedic surgeon, noted appellant's complaint of pain and stiffness in the right elbow and that he had limitations in using his right arm in activities of daily living. Dr. Brooks indicated that motions on left and right elbows respectively were extension 0/10 degrees and flexion 140/110 degrees. Crepitus was readily apparent in the right elbow with elbow motion, both palpably and audibly. Forearm pronation was 90/10 degrees and supination 0/90 degrees, respectively. Grip

[5] *Id.* (5th ed. 2000).

and pinch, were weaker on the right. Sensory testing revealed hypoesthesia throughout most of the right forearm and also involving the ulnar aspect of appellant's right hand, ring, and little fingers. Dr. Brooks diagnosed open fracture dislocation of the right elbow, including comminuted fractures of the radial head and neck, fractures of the olecranon and coronoid process, and tears of both the medial and lateral collateral ligaments, due to the February 9, 2011 employment injury. He further diagnosed post-traumatic arthritis of the right elbow, complicating the elbow fracture-dislocation, and right ulnar neuropathy, also complicating the elbow fracture-dislocation, status post submuscular ulnar nerve transposition.

Dr. Brooks indicated that, in accordance with Table 15-4, the radial head arthroplasty diagnosis, complicated by heterotopic ossification and ankylosis, was the highest causally related rating diagnosis, with an impairment range of 9 to 13 percent. He found a grade modifier of 2 for functional history, 3 for physical examination, and no modifier for clinical studies. Dr. Brooks applied the net adjustment formula and concluded that appellant had 13 percent right upper extremity permanent impairment based on the diagnosis of radial head arthroplasty.

Dr. Brooks further found that the A.M.A., *Guides* indicated that a peripheral nerve impairment could be combined with a DBI rating of the upper extremity level as long as the DBI rating did not encompass the nerve impairment. He advised that appellant's ulnar neuropathy was a separate and distinct diagnosis, which caused an increased impairment. Dr. Brooks utilized Table 15-23, Entrapment/Compression Neuropathy Impairment, and indicated that appellant had no modifier for test findings because there was no electrodiagnostic study, and he had a grade modifier of 3 for history due to constant hypoesthesia in the ulnar distribution. He further indicated that appellant had a modifier of 2 for physical examination due to decreased sensation. Dr. Brooks averaged the grade modifiers, concluding that appellant had grade modifier of 2 which under Table 15-23 which yielded an impairment rating of seven to nine percent. He concluded that, based on appellant's *Quick*DASH (Disabilities of the Arm, Shoulder, and Hand) score of 45, he had eight percent right upper extremity impairment due to his peripheral nerve injury. Dr. Brooks combined the 13 percent permanent impairment due to the radial head arthroplasty with the 8 percent permanent impairment due to the peripheral nerve injury and concluded that appellant had 20 percent permanent impairment of the right upper extremity.

On January 14, 2014 Dr. Slutsky again reviewed the medical record, including Dr. Brooks' report. He advised that the date of MMI was August 13, 2013, the date of appellant's impairment evaluation by Dr. Brooks. Dr. Slutsky agreed with Dr. Brooks' conclusion that appellant had 13 percent permanent impairment under Table 15-4. He determined, however, that appellant was not entitled to an additional impairment rating for the right ulnar nerve peripheral neuropathy. Dr. Slutsky noted that the condition was first diagnosed on June 1, 2011 during surgery and had not been accepted as causally related to the accepted employment injury. He concluded that appellant's final right upper extremity permanent impairment rating was 13 percent, based on the complicated right radial head arthroplasty.

By decision dated February 6, 2014, OWCP granted appellant a schedule award for 13 percent permanent impairment of the right upper extremity.

Appellant thereafter appealed to the Board. By decision dated January 17, 2017, the Board set aside the February 6, 2014 decision and remanded the case to OWCP to apply the standards

found in its decision *T.H.*[6] The Board instructed OWCP to develop a consistent method for calculating permanent impairment for upper extremities to be applied uniformly. After this and such other development deemed necessary, OWCP was to issue a *de novo* decision on appellant's claim for an upper extremity schedule award.[7]

Following the Board's January 17, 2017 decision, by letter dated May 17, 2017, OWCP asked appellant to furnish a medical report from his treating physician based upon recent examination findings. This was to include an impairment rating in accordance with the sixth edition on the A.M.A., *Guides*, including both the DBI and ROM methods, with an opinion as to whether appellant had reached MMI.

In correspondence dated June 12, 2017, appellant maintained that the medical evidence of record was sufficient to issue a schedule award.

On July 5, 2017 OWCP referred the record to Dr. Michael M. Katz, an OWCP medical adviser, who is Board-certified in orthopedic surgery. It asked Dr. Katz to provide an impairment rating utilizing both the DBI and ROM methods, if the A.M.A., *Guides* allowed the use of both.

In a July 6, 2017 report, Dr. Katz noted the accepted conditions and his review of the evidence. He advised that he agreed with Dr. Slutsky and Dr. Brooks that appellant had 13 percent permanent impairment as a result of the right elbow fracture and subsequent surgery/sequelae, by utilizing the DBI method under Table 15-4, Elbow Regional Grid. Dr. Katz disagreed with Dr. Slutsky regarding whether a peripheral nerve injury should be included, opining that a schedule award should include both an employment-related impairment and any impairment of the scheduled member present at the time of the impairment evaluation. As such, appellant would be entitled to an increased schedule award due to peripheral nerve injury. Dr. Katz advised that for Table 15-23 to be utilized, electrodiagnostic testing should be done, and that there was no such testing in this case. He found that, under Table 15-21, Peripheral Nerve Impairment, Upper Extremity, appellant had an additional 6 percent impairment for a peripheral nerve injury which, when combined with the 13 percent impairment, yielded a combined 18 percent right upper extremity permanent impairment. Dr. Katz further noted that the record did not support that the ROM method should be utilized as Dr. Brooks did not indicate that three independent measurements of each arc had been provided. He concluded that appellant had 18 percent right upper extremity permanent impairment which, following subtraction of the prior award of 13 percent, yielded an increased impairment of 5 percent, with August 13, 2013 the date of MMI.

In an August 28, 2017 treatment note, Dr. Hanel indicated that appellant was doing well with a slight increase in elbow stiffness. Right elbow ROM findings yielded flexion of 30, extension of 150, no supination, and no pronation. Dr. Hanel recommended a return in one year.

By decision dated October 26, 2017, OWCP found that appellant had not met the requirements for an increased schedule award.

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

[7] *Supra* note 3.

LEGAL PRECEDENT

It is the claimant's burden of proof to establish that he or she sustained permanent impairment of a scheduled member or function as a result of any employment injury.[8]

The schedule award provisions of FECA,[9] and its implementing federal regulations,[10] 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.[11] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[12]

The sixth edition requires identifying the impairment class for the class of diagnosis (CDX), 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]

Regarding the application of the ROM or DBI methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides:

> "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*

[8] *J.B.*, Docket No. 17-1907 (issued March 8, 2018).

[9] 5 U.S.C. § 8107.

[10] 20 C.F.R. § 10.404.

[11] *Id.* at § 10.404(a).

[12] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also id.* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[13] A.M.A., *Guides*, *supra* note 4 at 383-492.

[14] *Id.* at 411.

impairment rating for the diagnosis in question, the method producing the higher rating should be used." (Emphasis in the original.)[15]

The Bulletin further advises:

"If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* allow for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE.

"If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* do not allow for the use of ROM for the diagnosis in question, the DMA should independently calculate impairment using the DBI method and clearly explain in the report, citing applicable tables in Chapter 15 of the [A.M.A.,] *Guides*, that ROM is not permitted as an alternative rating method for the diagnosis in question.

"If the rating physician provided an assessment using the DBI method and the [A.M.A.,] *Guides* allow for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE.

"If the medical evidence of record is [in]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 the rating. After receipt of the second opinion physician's evaluation, the CE should route that report to the DMA for a final determination."

ANALYSIS

The Board finds this case not in posture for decision.

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

By decision dated January 17, 2017, the Board remanded the case for OWCP to reevaluate the extent of appellant's right upper extremity permanent impairment after it determined a consistent method for rating upper extremity impairments under the A.M.A., *Guides*.[16]

Following the Board's remand, OWCP advised appellant on May 17, 2017 that he should submit a new report from his treating physician in accordance with the sixth edition of the A.M.A., *Guides,* using both the DBI and ROM methods. The most recent medical report of record is that of Dr. Hanel dated August 28, 2017. However, he did not provide an impairment rating.

As noted, FECA Bulletin No. 17-06 provides that if OWCP does not receive medical evidence as requested within 30 days, then the CE should proceed with a referral for a second opinion evaluation to assess a claimant's impairment.[17] Thus, in this case OWCP should have referred appellant for a second opinion evaluation in June 2017, but it did not do so. Instead it asked its medical adviser Dr. Katz to provide an impairment rating utilizing both the DBI and ROM methods, if the A.M.A., *Guides* allowed the use of both. Following its receipt of the medical adviser's report, OWCP issued its October 26, 2017 decision.

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. While the claimant has the burden of proof to establish the claim, OWCP also has a responsibility in the development of the evidence.[18] Once OWCP undertakes development of the record, it has the responsibility to do so in a proper manner.[19]

The Board finds that, as OWCP did not follow the procedures outlined in FECA Bulletin No. 17-06, the case must be remanded for it to refer appellant for a second opinion evaluation and impairment rating, pursuant to the guidelines presented in FECA Bulletin No. 17-06.

The Board also notes that the A.M.A., *Guides* indicate in Figure 15-31 that a claimant can receive an impairment rating under both the DBI method and for a peripheral nerve impairment.[20] However, it has not been determined whether appellant's peripheral nerve injury was preexisting, therefore it is unclear whether the condition should be included in the impairment evaluation. Dr. Slutsky, an OWCP medical adviser, noted in a January 14, 2014 report that appellant was not entitled to an additional impairment rating for the right ulnar nerve peripheral neuropathy because it was first diagnosed on June 1, 2011, after the February 9, 2011 employment injury, and had not been accepted as employment related. On remand OWCP should also determine whether appellant is entitled to an additional impairment rating for the right ulnar nerve neuropathy.

The case will therefore be remanded to OWCP to refer appellant for a second opinion evaluation regarding appellant's right upper extremity impairment. After this and such additional

[16] *Supra* note 3.

[17] *Supra* note 16.

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

[19] *P.K.*, Docket No. 08-2551 (issued June 2, 2009).

[20] A.M.A., *Guides*, *supra* note 4 at 480.

development deemed necessary, OWCP shall issue a *de novo* decision regarding appellant's claim for an increased right upper extremity schedule award.[21]

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the October 26, 2017 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded to OWCP for proceedings consistent with this opinion of the Board.

Issued: November 9, 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

[21] *See J.F.*, Docket No. 17-1726 (issued March 12, 2018).