United States Department of Labor
Employees' Compensation Appeals Board

J.V., Appellant	)	
and	)	**Docket No. 18-1052**
	)	**Issued: November 8, 2018**
DEPARTMENT OF THE AIR FORCE, TRAVIS AIR FORCE BASE, 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 April 26, 2018 appellant filed a timely appeal from a December 6, 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 this case.

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 a schedule award, and whether he has established permanent impairment of his left upper extremity.

FACTUAL HISTORY

On December 17, 2013 appellant, then a 56-year-old cargo scheduler, filed an occupational disease claim (Form CA-2) alleging that he sustained arthritis at the base of his thumbs due to

[1] 5 U.S.C. § 8101 *et seq.*

tightening cargo nets for over 30 years.[2] He did not stop work, but the employing establishment indicated that it had modified his job duties. OWCP accepted the claim for bilateral localized primary osteoarthritis of the hands.

On May 7, 2015 appellant underwent an arthroplasty of the carpometacarpal (CMC) joint of the right thumb and a right one bone carpectomy and hemitrapezoidectomy. He stopped work on May 7, 2015 and returned to work on July 20, 2015.

Appellant, on November 25, 2015, filed a claim for a schedule award (Form CA-7). By letter dated December 3, 2015, OWCP advised him that the medical evidence of record was insufficient to establish that he had reached maximum medical improvement (MMI).

On January 15, 2016 Dr. Chunbo C. Cai, a Board-certified physiatrist, requested a copy of the letter from OWCP asking for an opinion regarding whether appellant had reached MMI. In a February 1, 2016 response, OWCP requested that Dr. Cai submit an impairment evaluation addressing whether appellant had reached MMI and providing a permanent impairment rating using the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3]

In a report dated February 18, 2016, Dr. Cai advised that she did not perform impairment ratings using the sixth edition of the A.M.A., *Guides*. She opined that appellant had reached MMI on January 28, 2016. Dr. Cai diagnosed osteoarthritis of the bilateral right first CMC joint. She found full strength of both wrists and measured range of motion of the wrists and thumbs bilaterally.[4]

On April 19, 2016 appellant advised OWCP that his physician did not perform ratings of permanent impairment using the sixth edition of the A.M.A., *Guides* and requested referral for an impairment evaluation.

OWCP, on August 5, 2016, referred him to Dr. Aubrey A. Swartz, a Board-certified orthopedic surgeon, for a second opinion examination regarding the extent of permanent impairment of the upper extremities.

Dr. Swartz, in a September 6, 2016 impairment evaluation, noted that appellant complained of difficulty climbing ladders and ratcheting loads due to his thumb condition. He noted that the surgery on his right thumb had resulted in decreased motion as opposed to the left thumb. Dr. Swartz discussed appellant's complaints of some numbness at the base of the right thumb around a branch of the radial nerve and pain at the base of both thumbs as demonstrated on a pain

[2] OWCP previously accepted that appellant sustained a right foot contusion on September 9, 2003 under File No. xxxxxx622.

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

[4] Dr. Cai measured range of motion of the wrists bilaterally as 60 degrees flexion, 50 degrees extension, 20 degrees radial deviation, and 30 degrees ulnar deviation. She measured motion at the right CMC joint of the thumb as 15 degrees flexion, 20 degrees extension, 70 degrees adduction, and 0 degrees abduction and at the left CMC joint as 15 degrees flexion, 15 degrees extension, 70 degrees adduction, and 0 degrees abduction.

drawing. He diagnosed an interposition arthroplasty of the CMC joint of the right thumb for osteoarthritis, left thumb osteoarthritis at the CMC joint, a right hemitrapezoidectomy for osteoarthritis of the right wrist scaphotrapezial joint, and status post arthroplasty of the scaphotrapezial joint of the right wrist. On examination, Dr. Swartz measured abduction of the CMC joint of the thumbs as 40 degrees on the right and 50 degrees on the left, flexion of the metacarpophalangeal (MP) joint of the thumbs as 30 degrees on the right and 70 degrees on the left, and flexion at the interphalangeal (IP) joint of the thumbs as 60 degrees on the right and 70 degrees on the left. On adduction, he found that appellant's right thumb missed the ulnar border by two centimeters and his left thumb missed the ulnar border by one and a half centimeters. Dr. Swartz measured eight centimeters of right and left thumb opposition. He found hypoesthesias near the scar over the right thumb and right radial wrist and normal left thumb and wrist sensation. Dr. Swartz measured range of motion of the wrists as 40 degrees palmar flexion on the right and 60 degrees on the left, 40 degrees dorsiflexion on the right and 60 degrees on the left, 15 degrees radical deviation on the right and 20 degrees on the left, and 20 degrees ulnar deviation on the right and 30 degrees on the left.

Dr. Swartz determined that, according to Table 15-2 on page 393 of the A.M.A., *Guides*, he should rate appellant's right thumb impairment using the range of motion (ROM) methodology given the findings on examination of motion loss. He found that 40 degrees abduction yielded two percent impairment of the digit, adduction of two centimeters yielded no impairment, and opposition of eight centimeters yielded no impairment. Dr. Swartz further determined that 30 degrees flexion at the MP joint yielded four percent impairment and 60 degrees IP joint flexion yielded one percent impairment. He combined the impairment values to find seven percent right thumb impairment, or three percent right upper extremity permanent impairment. Dr. Swartz found no change with the application of grade modifiers. He further determined that, for the right wrist, 40 degrees extension yielded three percent permanent impairment, 40 degrees flexion yielded three percent impairment, 15 degrees radial deviation yielded two percent impairment, and 20 percent ulnar deviation yielded two percent impairment, which he added to find 10 percent right upper extremity impairment. Dr. Swartz combined the impairment ratings to find a total right upper extremity permanent impairment of 13 percent.

For the left thumb, Dr. Swartz determined that 50 degrees abduction yielded no impairment, one and a half centimeters of adduction yielded no impairment, eight centimeters of opposition yielded no impairment, 70 degrees of MP joint flexion yielded no impairment, and 70 degrees IP joint flexion yielded no impairment. He thus found that appellant had no permanent impairment of the left upper extremity due to loss of range of motion. Regarding a diagnosis-based impairment (DBI) estimate, Dr. Swartz determined that appellant had no instability of the CMC joint and thus no permanent impairment using Table 15-2 of the A.M.A., *Guides*.

An OWCP medical adviser reviewed the evidence on October 24, 2016. He concurred with Dr. Swartz' finding that appellant had 13 percent right upper extremity impairment and no impairment of the left upper extremity. The medical adviser determined that Dr. Swartz properly used the ROM methodology as directed by the wrist regional grid at Table 15-3 and the digit regional grid at Table 15-2 in the absence of normal motion.

By decision dated December 20, 2016, OWCP granted appellant a schedule award for 13 percent permanent impairment of his right upper extremity. It determined that he had no

impairment of his left upper extremity. The period of the award ran for 283.92 days[5] from September 6, 2016 to July 16, 2017.

On September 15, 2017 appellant requested reconsideration. In a September 9, 2017 statement, he advised that he experienced reduced motion, pain with movement, stiffness, and difficulty grasping and holding items in both thumbs equally. Appellant maintained that he had retired due to his injury and his physician determined that he was totally disabled.

In a February 2, 2017 work status report, Dr. Richard George Lasslo, Board-certified in family medicine, found that appellant was disabled from work due to "blindness, hand pain, and psychological symptoms."

By decision dated December 6, 2017, OWCP denied modification of its December 20, 2016 decision. It found that Dr. Lasslo did not address the extent of appellant's permanent impairment.

On appeal appellant asserts that he has problems with both thumbs and had to retire due to his injury which resulted in a loss of income. He notes that his physician found that he was permanently disabled. Appellant relates that he has not found a physician in his area who will perform the necessary impairment evaluation.

LEGAL PRECEDENT

The schedule award provisions of FECA,[6] and its implementing federal regulations,[7] 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.[8] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[9]

The sixth edition requires identifying the impairment class of diagnosis (CDX) condition, which is then adjusted by grade modifiers based on functional history (GMFH), physical

[5] The decision incorrectly provides that the schedule award ran for 283.92 weeks of compensation. Pursuant to 5 U.S.C. § 8107(c)(1), a total loss of use of an arm (100 percent permanent impairment) provides for 312 weeks of compensation. Thus, 13 percent permanent impairment of an arm is equivalent to 40.56 weeks of compensation (312 weeks x 13 percent) or 283.92 days as provided in the December 20, 2016 schedule award.

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id.* at § 10.404(a).

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

examination (GMPE), and clinical studies (GMCS).[10] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

The A.M.A., *Guides* also provide that ROM impairment methodology is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other DBI sections are applicable.[11] 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 measured and added.[12] 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.[13]

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology *versus* the ROM methodology for rating upper extremity impairments.[14] 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).[15]

ANALYSIS

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

In a report dated September 6, 2016, Dr. Swartz found that appellant's right thumb impairment should be calculated using the ROM methodology as Table 15-2 of the A.M.A., *Guides,* the digit regional grid, provided a rating for a joint impairment of the thumb only if there

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

[11] *Id*. at 461.

[12] *Id*. at 473.

[13] *Id*. at 474.

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

[15] *Id*.

is normal range of motion. As he did not have normal motion, Dr. Swartz properly rated appellant's right thumb impairment using the ROM methodology set forth at Table 15-30 on page 468. He further found normal range of motion of the left thumb and no impairment of the CMC joint under Table 15-2. Dr. Swartz concluded that appellant had three percent right upper extremity impairment due to loss of motion of the right thumb and no impairment of the left thumb. He also rated appellant's right wrist using the range of motion method. Table 15-3, the wrist regional grid, provides ratings for a wrist arthroplasty with normal motion or for unstable or infected results, and indicates as an alternative rating the impairment using the ROM method. An OWCP medical adviser reviewed Dr. Swartz' opinion and concurred with his use of the ROM to rate the impairment of the right wrist and thumb.

As noted, FECA Bulletin No. 17-06 indicates that in measuring range of motion, the evaluator should obtain three independent measurements and the greatest measurement used to determine the extent of impairment.[16] The record does not establish that Dr. Swartz obtained three measurements prior to rating the extent of appellant's permanent impairment. FECA Bulletin No. 17-06 provides that the CE should instruct the physician to obtain three independent measurements.

On remand OWCP should obtain a supplemental report from Dr. Swartz containing three independent range of measurements for the thumbs and right wrist pursuant to FECA Bulletin No. 17-06. After such further development as deemed necessary, OWCP shall issue a *de novo* decision regarding appellant's entitlement to a schedule award for a permanent impairment of the upper extremities.[17]

CONCLUSION

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

[16] *Id*.

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

ORDER

IT IS HEREBY ORDERED THAT the December 6, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: November 8, 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