United States Department of Labor
Employees' Compensation Appeals Board

J.B., Appellant	)	
and	)	**Docket No. 18-0419**
	)	**Issued: October 1, 2018**
DEPARTMENT OF THE NAVY, PORTSMOUTH NAVAL SHIPYARD, Portsmouth, NH, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On December 21, 2017 appellant filed a timely appeal from a November 30, 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 claim.

ISSUE

The issue is whether appellant has established more than 30 percent permanent impairment of the left first finger, for which he previously received schedule award compensation.

FACTUAL HISTORY

On November 24, 2015 appellant, then a 32-year-old heavy mobile equipment leader, filed a traumatic injury claim (Form CA-1) alleging that, on October 22, 2015, a spring-loaded reel

[1] 5 U.S.C. § 8101 *et seq.*

released and struck his left index finger. He was treated at the emergency department the same day for a laceration of left index finger, distal phalanx fracture left index finger, and left index finger extensor tendon injury. Appellant returned to full-time, modified-duty work on November 3, 2015 and full-duty work on January 28, 2016. On February 10, 2016 OWCP accepted the claim for a comminuted fracture of the distal phalanx, left index finger.

On August 8, 2016 appellant filed a claim for a schedule award (Form CA-7).

As appellant was unable to obtain an impairment rating from his own physician, OWCP referred him to Dr. Frank A. Graf, a Board-certified orthopedic surgeon, for an impairment evaluation. In a February 28, 2017 report, Dr. Graf set forth examination findings. The examination revealed that the left index finger had a 21-degree flexion extension deficit with inability to fully extend the index finger. When closing his hand, appellant could not curl the distal segment of the index finger into the palm. There was slight duskiness to the distal segment of the index finger compared to the adjacent fingers. The pulp of the distal segment was smaller and atrophied on the left compared to the right. There was slight hyperextension of the proximal interphalangeal (PIP) joint at the index finger on the left with the Reston pinch gauge on the right 5.4 and 5.2; left 3.5 and 3 kilograms (kg). Jamar dynamometer measurements right 46, 43 and 42 kg; left 44, 43 and 42 kg. Dr. Graf diagnosed crush injury with severe comminution of the distal phalanx; disruption of extensor mechanism and flexor profundus attachments distal phalanx; extensor lag to the distal interphalangeal (DIP) joint index finger; onychogryposisi to the nail with disruption of the nail bed; avoidance phenomenon left index finger in hand functions; microcirculatory changes with increased sensitivity to cold; and pulp atrophy distal segment with sensory pattern change to touch. He estimated that appellant reached maximum medical improvement (MMI) six months after the date of injury. Based on his evaluation, Dr. Graf found that appellant had 30 percent permanent impairment of the left first finger or 5 percent permanent impairment of the left upper extremity under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2] He indicated that, under Table 15-2, appellant had a class 3 or 30 percent default impairment of the index finger of his dominant left hand as a result of the above diagnoses and consequences of his injury pattern. Dr. Graf applied the net adjustment formula, (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) or (3-3) + (3 -3) + (3-3), and found a net adjustment of zero. Utilizing Table 15-12, he converted the 30 percent impairment of the left index finger to 6 percent impairment of the hand and 5 percent impairment of the upper extremity.

In a May 17, 2017 report, Dr. William Tontz, Jr., an orthopedic surgeon and OWCP medical adviser, reviewed the statement of accepted facts (SOAF) and Dr. Graf's impairment rating. He indicated that the date of MMI was April 22, 2017. Utilizing Table 15-2 on page 393 of the A.M.A., *Guides,* Dr. Tontz stated that the default rating for distal phalanx fracture was four percent upper extremity permanent impairment. He opined that appellant would have a net adjustment up to five percent permanent left upper extremity impairment, for a class 3 impairment rating.

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

On August 11, 2017 OWCP requested that its medical adviser explain the discrepancy between the impairment ratings of the digit, hand, and upper extremity.

In an August 22, 2017 addendum report, Dr. Tontz stated that the claim was accepted for displaced fracture of distal phalanx of the left index finger, closed fracture. He stated that the fracture had resulted in loss of motion as evidenced by the examination note. Dr. Tontz opined that the net impairment rating was five percent for the left upper extremity based on page 393 of the A.M.A., *Guides*.

By decision dated November 30, 2017, OWCP granted a schedule award for 30 percent permanent impairment of the left first finger. The awarded covered a 13.8-week period from April 22 to July 27, 2016.

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.[3] 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.[4] 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 A.M.A., *Guides* as the appropriate standard for evaluating schedule award losses.[5] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[6]

The A.M.A., *Guides* provide a diagnosis-based impairment (DBI) method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF) for upper extremity impairments. The evaluator identifies the impairment for the Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[7] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX).[8]

[3] *See* 20 C.F.R. §§ 1.1-1.4.

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

[5] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[6] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (March 2017); Federal Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017).

[7] A.M.A., *Guides* 385-419; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[8] *Id.*

The A.M.A., *Guides* also provide that range of motion (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.[9] 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.[10] 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.[11]

OWCP issued FECA Bulletin No. 17-06 to explain the use of DBI methodology *versus* ROM methodology for rating of upper extremity impairments.[12] 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 the 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 rate 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.)[13]
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> The Bulletin further advises:
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> "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."[14]

[9] *Id.* at 461.

[10] *Id.* at 473.

[11] *Id.* at 474.

[12] FECA Bulletin No. 17-06. This Bulletin was effective for all decisions issued by OWCP on and after May 8, 2017.

[13] *Id.*

[14] *Id.*

ANALYSIS

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

Dr. Graf provided range of motion findings for appellant's left index finger. However, he did not provide an impairment rating based upon ROM methodology. Rather he only used the range of motion findings in applying the DBI methodology pursuant to Table 15-2 of the A.M.A., *Guides*, for a diagnosis of fracture of the distal phalanx of the left index finger.[15]

OWCP's DMA reviewed Dr. Graf's report and rated appellant's permanent impairment of the left index finger under Table 15-2, for a DBI rating. The Board notes that Table 15-2, the Digit Regional Grid, does allow, by asterisk, that fractures of the digits be alternatively evaluated by as a ROM impairment.[16] Under FECA Bulletin No. 17-06:

> *"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.)[17]

Therefore, the DMA should have independently calculated appellant's impairment rating using both the ROM and DBI method and identified the higher rating for the claims examiner.

The case will therefore be remanded for further development consistent with OWCP procedures found in FECA Bulletin No. 17-06. Following this and any other development deemed necessary, OWCP shall issue a *de novo* decision.[18]

CONCLUSION

The Board finds this case not in posture for decision.

[15] Dr. Graf indicated that the rating did not accurately reflect the functional significance of the distal segment injury appellant experienced. *See Dennis R. Stark*, 57 ECAB 306 (2006) (where the residuals of an injury to a scheduled member of the body extend into an adjoining area of a member also enumerated in the schedule, such as an injury of a finger into a hand, or 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).

[16] *See* A.M.A., *Guides* 393, Table 15-2.

[17] *Supra* note 12.

[18] *See B.N.*, Docket No. 17-1923 (issued April 17, 2018).

ORDER

IT IS HEREBY ORDERED THAT the November 30, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with the above opinion.

Issued: October 1, 2018
Washington, DC

Patricia H. Fitzgerald, Deputy 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