United States Department of Labor
Employees' Compensation Appeals Board

C.R., Appellant	)	
and	)	**Docket No. 18-0487**
	)	**Issued: September 7, 2018**
DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE, Richmond, VA, 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 January 4, 2018 appellant filed a timely appeal from a July 18, 2018 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 this case.

ISSUE

The issue is whether appellant has established more than three percent permanent impairment of his left upper extremity, for which he has previously received schedule award compensation.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On September 22, 2015 appellant, then a 38-year-old special agent, filed a traumatic injury claim (Form CA-1) alleging that, on September 15, 2015, he injured his ring finger on his left hand while in the performance of duty. He did not stop work. OWCP accepted the claim for left finger acute boutonniere injury.

On September 29, 2016 appellant filed a schedule award claim (Form CA-7).

In a report dated September 2, 2016, Dr. Kevin R. Krafft, a Board-certified physiatrist and sports medicine physician, provided an impairment rating using the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2] He detailed appellant's medical history and reported the findings of his examination, noting that appellant had residual decreased range of motion in his left ring finger. Dr. Krafft opined that based on appellant's decreased range of motion he had four percent hand or left upper extremity permanent impairment or two percent whole person impairment using the sixth edition of the A.M.A., *Guides.*

OWCP referred Dr. Krafft's September 6, 2016 report and the case record to an OWCP district medical adviser (DMA), and requested that he provide an opinion regarding appellant's left ring finger permanent impairment under the sixth edition of the A.M.A., *Guides*.

In an October 11, 2016 report, the DMA reviewed the medical evidence of record including Dr. Krafft's impairment rating. He found Dr. Krafft's report insufficient to support appellant's claim as no documentation regarding range of motion was detailed. The DMA recommended that OWCP obtain a supplemental report from Dr. Krafft detailing impairment findings using Table 15-31 of the A.M.A., *Guides*.

In a January 3, 2017 addendum, Dr. Krafft related that appellant had four percent hand or left upper extremity permanent impairment or two percent permanent impairment of the whole person. Using Table 15-31 to evaluate permanent impairment due to restricted range of motion (ROM) of the fingers, he found that appellant had 12 percent permanent impairment of his left ring finger due to 55 degrees of flexion of the distal interphalangeal (DIP) joint and -20 degrees of extension of the DIP joint. Dr. Krafft found 28 percent permanent impairment of the left ring finger due to 85 degrees of flexion of the proximal interphalangeal joint (PIP) and -19 degrees extension of the PIP joint. He also found four percent permanent impairment of the left ring finger due to 15 degrees extension of the metacarpophalangeal (MCP) joint and 90 degrees flexion of the MCP joint. Dr. Krafft combined these values and concluded that appellant had 40 percent permanent impairment of his left ring finger, which equaled 4 percent permanent impairment of his left upper extremity or 2 percent whole person permanent impairment.

In a February 9, 2017 report, the DMA reviewed Dr. Krafft's September 2, 2016 report and January 3, 2017 addendum and concluded that appellant had three percent left upper extremity permanent impairment. He advised that Dr. Krafft incorrectly assigned 14 percent for 85 degrees of flexion for the left ring finger PIP joint. Thus, the DMA found a total combined value of 33

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

percent, which equaled 3 percent left upper extremity permanent impairment. He determined the date of maximum medical improvement to be September 2, 2016, the date of Dr. Krafft's examination.

By decision dated February 14, 2017, OWCP granted appellant a schedule award for three percent permanent impairment of his left upper extremity. The award ran for 9.36 weeks, covering the period September 2 to November 6, 2016. OWCP based this award on the DMA's February 10, 2017 impairment rating.

In a form dated and postmarked February 28, 2017, appellant requested a review of the written record by an OWCP hearing representative.

On February 23, 2017 Dr. Krafft noted his disagreement with the DMA's rounding down for the 85 degrees left ring finger PIP flexion. He noted that 85 degrees is midpoint between the tables for 80 degrees and 90 degrees. Thus, half of 21 percent + 6 percent = 13.5 percent, which he rounded up to 14 percent.

In a statement dated February 28, 2017, appellant argued that Dr. Krafft correctly calculated his impairment rating. He noted that the DMA rounded down for his PIP flexion of 85 degrees as there is no value set for 85 degrees in the table. Dr. Krafft informed him that his finding of 14 percent for PIP flexion resulted from him extrapolating between the table for 50 to 80 degrees and 90 degrees.

By decision dated July 18, 2017, an OWCP hearing representative affirmed the February 14, 2017 schedule award determination. She found the DMA's report constituted the weight of the medical opinion evidence as he provided rationale for his impairment rating.

LEGAL PRECEDENT

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

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

[3] 5 U.S.C. § 8107(c)

[4] 20 C.F.R. § 10.404; *see also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[5] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017).

Examination (GMPE), and Clinical Studies (GMCS).[6] 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.[7] 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.[8] 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.[9]

OWCP issued FECA Bulletin No. 17-06 to explain the use of the diagnosis-based impairment (DBI) methodology versus the ROM methodology basis for rating of upper extremity impairments.[10] 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.)[11]
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> The Bulletin further advises:
>
> "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

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

[7] *Id.* at 461.

[8] *Id*. at 473.

[9] *Id*. at 474.

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

[11] *Id.*

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."[12]

ANALYSIS

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

As noted above, FECA Bulletin No. 17-06 provides that, if the rating physician provided an assessment using the ROM method and the A.M.A., *Guides* allows 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.[13]

The Board therefore finds that this case requires further development of the medical evidence. Since Dr. Krafft provided a rating based upon appellant's loss of ROM of the left ring digit, which is allowed (by asterisk) pursuant to Table 15-2 of the A.M.A., *Guides*, the DMA should have independently calculated appellant's impairment using both the ROM and DBI methods and identified the higher rating for the claims examiner. If the medical evidence of record was not sufficient for the DMA to render a rating using the ROM or DBI method, he should advise as to the medical evidence necessary to complete the rating.[14]

This case will therefore be remanded for application of the new OWCP procedures found in FECA Bulletin No. 17-06. After such further development of the medical evidence as necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

[12] *Id.*

[13] *Supra* note 10; *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

[14] *Id.*

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated July 18, 2017 is set aside and the case is remanded for further proceedings consistent with the above opinion.

Issued: September 7, 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