United States Department of Labor
Employees' Compensation Appeals Board

C.C., Appellant	)	
and	)	**Docket No. 19-0467**
	)	**Issued: August 7, 2019**
DEPARTMENT OF HOMELAND SECURITY, U.S. SECRET SERVICE, Washington, DC, 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
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On December 30, 2018 appellant filed a timely appeal from a November 21, 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 over the merits of this case.

ISSUE

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

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On April 13, 2015 appellant, then a 31-year-old police officer, filed a traumatic injury claim (Form CA-1) alleging that on April 12, 2015 he sustained lacerations to his small finger and palm and multiple puncture wounds at the top of his hand when his assigned canine bit his right hand while in the performance of duty. He did not work from April 13 to May 13, 2015. OWCP accepted appellant's claim for open dog bite of the right hand/fingers, right hand traumatic compartment syndrome, right thumb felon, and right hand cellulitis.

In April and May 2015, appellant underwent several surgeries to his right hand, including right carpal tunnel release, decompression of the right hand and thumb with debridement of necrotic tissue, and fasciotomy and debridement of the right dorsal and volar hand, right thumb, and right small finger. He was released to full duty on July 31, 2015.

On June 9, 2016 appellant filed a claim for a schedule award (Form CA-7).

In a development letter dated June 14, 2016, OWCP advised appellant of the type of evidence needed to establish his schedule award claim, including a statement from his attending physician that the accepted condition(s) had reached maximum medical improvement (MMI) and an impairment rating utilizing the appropriate portions of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (A.M.A., *Guides*).[2] It afforded him 30 days to submit the necessary evidence. No additional evidence was received.

On July 20, 2016 OWCP referred appellant, along with a statement of accepted facts and the medical record, to Dr. David Allen Smith, for a second opinion examination. In an August 12, 2016 report, Dr. Smith reviewed appellant's history of injury and provided examination findings. He indicated that appellant had reached MMI. Dr. Smith referenced Table 15-2, *Digital Regional Grid*, and Table 15-12, *Impairment Values Calculated from Digit Impairment*, of the A.M.A., *Guides* and determined that appellant had two percent right upper extremity permanent impairment due to his right thumb and little finger. He also utilized Table 15-3,[3] *Wrist Regional Grid*, and determined that appellant had six percent permanent impairment for the diagnosis of right wrist/hand laceration for a total of eight percent right upper extremity impairment.

In a September 14, 2016 report, Dr. David I. Krohn, a Board-certified internist serving as a district medical adviser (DMA), reviewed Dr. Smith's August 12, 2016 report and disagreed with his impairment rating. He determined that appellant had one percent right upper extremity permanent impairment for his right thumb and fifth finger. Dr. Krohn noted a date of MMI of August 12, 2016, the date of Dr. Smith's second-opinion report.

OWCP determined that a conflict in medical opinion existed Dr. Smith and Dr. Krohn regarding the degree of appellant's right upper extremity permanent impairment. It referred appellant to Dr. Kristin Nesbitt, a Board-certified orthopedic hand surgeon, for an impartial medical examination in order to resolve the conflict. In a July 31, 2017 report, Dr. Nesbitt related

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

[3] Dr. Smith incorrectly labeled this Grid as Table 16-3.

appellant's current complaints of some residual discomfort in his right hand, difficulty with gripping and twisting, and some weakness compared to his left hand. Upon physical examination of appellant's right hand, she observed well-healed surgical incisions and initial dog bite wound with some subjective numbness. Dr. Nesbitt reported that appellant had full flexion at metacarpophalangeal (MP), proximal interphalangeal (PIP), and distal interphalangeal (DIP) joints of his digits and full flexion of the MP and IP joint of the right thumb. Wrist compression, Tinel's sign, and Phalen's tests were negative at the wrist. Dr. Nesbitt indicated that she was in agreement with Dr. Smith's finding of eight percent permanent impairment. However, she further reported that she preferred to use the fourth edition of the A.M.A., *Guides*[4] and calculated that appellant had an overall permanent impairment of 10 percent right upper extremity impairment based on loss of range of motion (ROM) of the small finger and loss of strength.

In a letter dated November 30, 2017, OWCP sought clarification from Dr. Nesbitt regarding her impairment rating for appellant and requested that she provide an addendum report which provided an opinion regarding permanent impairment in accordance with the sixth edition of the A.M.A., *Guides.*

In a December 12, 2017 letter, Dr. Nesbitt noted that she had received OWCP's November 30, 2017 letter and reported that she was not redoing the impairment rating. She again noted that she was in agreement with Dr. Smith's finding of eight percent right upper extremity impairment.

In a letter dated January 18, 2018, OWCP requested that Dr. Smith provide an impairment rating that utilized both the diagnosis-based impairment (DBI) and ROM methodologies.

After several unsuccessful attempts to retrieve an addendum report from Dr. Smith, OWCP referred appellant to Dr. Stuart J. Gordon, a Board-certified orthopedic surgeon, for a second-opinion examination. In an August 15, 2018 report, Dr. Gordon related appellant's current complaints of significant pain in the right hand and difficulty with working in a full-duty capacity. He discussed appellant's history of injury and reviewed his medical records. Upon examination of appellant's right hand, Dr. Gordon observed limited dorsiflexion to 70 degrees. Examination of his right wrist demonstrated atrophy of his thenar eminence and half-grade of grip strength weakness. Dr. Gordon noted full ROM, but pain on stress testing. He reported a *Quick*DASH score of 14.

Dr. Gordon provided examination findings for all of appellant's digits of the right hand. With respect to appellant's right thumb, he noted pain to palpation along the thumb flexor and no triggering, Finkelstein abnormality, or CMC irritability. Examination of appellant's right index finger demonstrated no irritability to the MP, PIP, or DIP joints. With respect to his right long ray, Dr. Gordon reported irritability and pain to palpation at the MP joint and sensitivity and pain along the volar aspect of the PIP joint. No triggering or irritability was noted. Examination of appellant's right small finger demonstrated sensitivity and discomfort to palpation over the proximal phalangeal segment. Dr. Gordon diagnosed severe injury of the right hand, post-traumatic deep space abscess; and right thumb felon status post debridement, post-traumatic injury of the right

[4] A.M.A., *Guides* (4th ed. 1993).

long finger, MP and PIP joints, residuals; and post-traumatic injury of the right small finger, MP and PIP joints, residuals.

Utilizing Table 15-2, *Digit Regional Grid*, Dr. Gordon determined that appellant had a class 1 diagnosis (CDX) for his right small finger under the of a healed minor soft tissue injury. He assigned grade modifiers of 3 for clinical studies (GMCS) and 1 for physical examination (GMPE) and functional history (GMFH), which resulted in six percent permanent digit impairment. Regarding appellant's right long finger, Dr. Gordon assigned a CDX of 1 (healed minor soft tissue injury) and grade modifiers of 2 GMCS, 1 GMPE, and 1 GMCS, which resulted in five percent permanent digit impairment. With regard to appellant's right thumb, he assigned a CDX of 1 (healed minor soft tissue injury) and grade modifiers of 3 GMCS, 1 GMPE, and 1 GMFH, which resulted in six percent digit impairment. Dr. Gordon converted each digit impairment to an upper extremity impairment of one percent (right small finger), one percent (right long finger), and two percent (right thumb) for a combined of four percent right upper extremity pursuant to the Combined Values Chart of the A.M.A., *Guides*. For appellant's right wrist condition, he referenced Table 15-3, *Wrist Regional Grid*, and determined that the closest diagnosis would be for wrist laceration. Dr. Gordon assigned a CDX of 1 and grade modifiers of 2 GMCS, 1 GMPE, and 1 GMFH for a net adjustment to six percent right upper extremity permanent impairment. He concluded that appellant had a combined 10 percent permanent impairment of his right upper extremity.

In a November 5, 2018 report, Dr. James W. Butler, Board-certified in preventive and occupational medicine serving as the DMA, reviewed Dr. Gordon's August 15, 2018 second-opinion report. He indicated that while the ROM methodology may be used to rate impairment, there was no significant ROM deficit noted by Dr. Gordon. The DMA referenced Table 15-3 and assigned a CDX of 1 for right wrist laceration (minor soft tissue injury). He assigned grade modifiers of 0 GMFH (*Quick*DASH score of 14), 0 GMCS (no available clinical studies or relevant findings), and 2 GMPE (moderate palpatory findings), which resulted in a net adjustment of -1 for a total of four percent right upper extremity permanent impairment due to the right wrist condition. Dr. Butler also determined impairment rating for the thumb and index finger. He assigned a CDX of 1 for each digit (residual symptoms and consistent objective findings) and grade modifiers of 0 GMFH and 0 GMCS (no available clinical studies or relevant findings) and 2 GMPE (moderate palpatory findings) for a net adjustment of -1, resulting in a total of three percent permanent digit impairment for the thumb and long finger and converted those findings to two percent of the right upper extremity. Dr. Butler concluded that appellant had a combined right upper extremity impairment of six percent. He reported that appellant was at MMI as of August 15, 2018, the date of Dr. Gordon's second opinion report.

By decision dated November 21, 2018, OWCP granted appellant a schedule award for six percent permanent impairment of the right upper extremity, based on the DMA's November 5, 2018 report. The period of the award ran for 14.64 weeks from August 15 to November 25, 2018.

LEGAL PRECEDENT

The schedule award provisions of FECA[5] and its implementing regulations[6] 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. FECA, however, does not specify the manner in which the percentage of loss of a member 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 and the Board has concurred in such adoption.[7] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, published in 2009, is used to calculate schedule awards.[8]

In addressing impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated.[9] With respect to the wrist, reference is made to Table 15-3 (Wrist Regional Grid)[10] and Table 15-2 (Digit Regional Grid).[11] After a class of diagnosis (CDX) is determined (including identification of a default grade value), the impairment class is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[12] The net adjustment formula is (GMFH – CDX) + (GMPE – CDX) + (GMCS – CDX).[13]

The A.M.A., *Guides* also provide that 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.[14] 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 combined.[15] Adjustments for functional history may be made if the evaluator

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404 (1999).

[7] *Id.* at 10.404(a); *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

[8] 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).

[9] *T.T.*, Docket No. 18-1622 (issued May 14, 2019).

[10] A.M.A., *Guides* 395-97.

[11] *Id.* at 391-94.

[12] *Id.* at 383-492; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[13] *Id.* at 411.

[14] *Id.* at 461.

[15] *Id.* at 473.

determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[16]

OWCP procedures provide: "if there was a second opinion examination, and the DMA provides a detailed and rationalized opinion in accordance with the A.M.A., *Guides*, but does not concur with the second opinion physician's impairment rating the [claims examiner] CE should seek clarification or a supplemental report from the second opinion examiner. After receiving clarification, the CE should refer the case back to the DMA for review.[17]

ANALYSIS

The Board finds that this case is not in posture for decision as OWCP did not follow proper procedures.

The Board initially notes that OWCP found a conflict in medical opinion between Dr. Smith, OWCP's second-opinion examiner, and Dr. Krohn, the initial DMA, and referred appellant to Dr. Nesbitt for an impartial medical examination in order to resolve the conflict in medical opinion evidence remains regarding the degree of appellant's right upper extremity impairment. Section 8123(a) of FECA, however, provides that referral for an impartial or referee examination is necessary if there is a disagreement between the physician making the examination for the United States and the physician of an employee.[18] As both Dr. Smith and Dr. Krohn were OWCP referral physicians, there was no conflict pursuant to 5 U.S.C. § 8123(a) and the referral to Dr. Nesbitt was for a second opinion examination.[19]

In a July 31, 2017 report, Dr. Nesbitt reviewed appellant's history and provided examination findings. She related that she preferred to use the fourth edition of the A.M.A., *Guides* and calculated that he had a combined 10 percent right upper extremity permanent impairment based on loss of ROM of the right small finger and loss of strength. In a December 12, 2017 supplemental report, Dr. Nesbitt indicated that she would not provide an impairment rating in accordance with the sixth edition of the A.M.A., *Guides.* As she did not provide an impairment rating which conformed to the proper edition of the A.M.A., *Guides*, her report lacked probative value.[20]

[16] *Id.* at 473-74.

[17] *Supra* note 6 at Chapter 2.808.6(e) (March 2017).

[18] 5 U.S.C. § 8123(a); *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

[19] *See B.T.*, Docket No. 16-1319 (issued April 25, 2017) (the Board found that at the time of the referral for a permanent impairment rating there was no conflict in medical opinion evidence; therefore, the referral was for a second opinion examination); *see also Cleopatra McDougal-Saddler*, 47 ECAB 480 (1996) (the Board found that, as there was no conflict in medical opinion evidence, the report of the physician designated as the impartial medical examiner was not afforded the special weight of the evidence, but was considered for its own intrinsic value as he was a second opinion specialist).

[20] *See P.B.*, Docket No. 17-1046 (issued January 2, 2018).

OWCP subsequently referred appellant to Dr. Gordon for another second-opinion examination. In an August 15, 2018 report, Dr. Gordon reviewed appellant's medical records and conducted an examination of his right wrist and hand. He referenced specific tables in the A.M.A., *Guides* and provided grade modifiers and calculated that appellant had 4 percent right upper extremity impairment due to his right small finger, right long finger, and right thumb, and 6 percent permanent impairment due to his right wrist laceration for a combined 10 percent right upper extremity permanent impairment.

In a November 5, 2018 report, Dr. Butler, serving as a DMA, noted his disagreement with Dr. Gordon's impairment rating and determined that appellant had four percent permanent impairment due to his right wrist and two percent permanent impairment due to his right thumb and index finger for a combined six percent right upper extremity permanent impairment.

By decision dated November 21, 2018, OWCP granted appellant a schedule award for six percent permanent impairment based on the November 5, 2018 DMA report.

As noted above, OWCP procedures provide: "if there was a second opinion examination, and the DMA provides a detailed and rationalized opinion in accordance with the A.M.A., *Guides*, but does not concur with the second opinion [physician's] impairment rating the [claims examiner] CE should seek clarification or a supplemental report from the second opinion examiner. After receiving clarification, the CE should refer the case back to the DMA for review.[21] Furthermore, the Board notes FECA Bulletin No. 17-06[22] requires application of the sixth edition of the A.M.A., *Guides* when they allow for use of the ROM methodology to determine permanent impairment for a specific diagnosis.

In this case, Dr. Gordon, the second opinion examiner, determined in an August 15, 2018 report, that appellant had 10 percent right upper extremity impairment. Dr. Butler, serving as the DMA, disagreed with Dr. Gordon's impairment rating and calculated that appellant had six percent right upper extremity permanent impairment. Both Dr. Gordon and the DMA referenced appropriate tables in the A.M.A., *Guides* and explained how they applied the provisions of the A.M.A., *Guides* when making calculating permanent impairment. OWCP, however, failed to seek clarification from Dr. Gordon after the DMA disagreed with his impairment rating. The need for additional medical development and clarification regarding the degree of appellant's right upper extremity permanent impairment is especially needed in this case since Dr. Smith also determined in his August 12, 2016 second opinion report that appellant had 10 percent right upper extremity permanent impairment. Here, the A.M.A., *Guides* provides that the right wrist impairment can alternatively be rated using the ROM methodology, as allowed under FECA Bulletin No. 17-06. Neither Dr. Gordon nor Dr. Butler, however, provided a rating of impairment based on the ROM methodology for the wrist.

As OWCP failed to follow proper procedure, the case must, therefore, be remanded to OWCP so that it may seek clarification and obtain a supplemental report from Dr. Gordon regarding the degree of appellant's right upper extremity impairment. On remand OWCP should

[21] *Supra* note 15.

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

request that Dr. Gordon provide an impairment rating that utilizes both the DBI and ROM methodology as required by FECA Bulletin No. 17-06 and other procedures as set forth herein. After such further development as OWCP deems necessary, it shall issue a *de novo* decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the November 21, 2018 merit decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: August 7, 2019
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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