United States Department of Labor
Employees' Compensation Appeals Board

L.C., Appellant	)	
and	)	**Docket No. 19-0564**
	)	**Issued: September 16, 2019**
DEPARTMENT OF VETERANS AFFAIRS, SOUTHERN ARIZONA VETERANS ADMINISTRATION HEALTH CARE SYSTEM, Tucson, AZ, 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
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On January 16, 2019 appellant filed a timely appeal from a July 27, 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.[2]

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the July 27, 2018 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: 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 additional evidence for the first time on appeal. *Id.*

ISSUE

The issue is whether appellant has met her burden of proof to establish greater than 13 percent permanent impairment of the right upper extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On November 3, 2011 appellant, then a 51-year-old medical supply technician, filed a traumatic injury claim (Form CA-1) alleging that on October 25, 2011 she punctured her right index finger on a small metal protrusion as she grabbed a metal pan filled with sterilized instruments while in the performance of duty. On October 29, 2011 she underwent surgical release of first annular (A1) pulley, release flexor tendon sheath, incision and drainage of abscess and drainage of tenosynovitis. Appellant returned to light-duty work on December 6, 2011. She returned to regular duty on January 4, 2012. On January 31, 2012 OWCP accepted appellant's claim for open wound of the right finger with complications and infection.

In a June 14, 2012 note, appellant's physician, Dr. Warren Breidenbach, a Board-certified plastic surgeon, released her from his care and diagnosed symptom magnification and possible mild irritation at the A1 pulley. He found that she had no permanent impairment, and that she could perform full-duty work. On January 16, 2013 Dr. Breidenbach performed surgery for saddle deformity of the right index finger. Based on his restrictions appellant returned to work on April 1, 2013 in an "alternative work assignment." She returned to regular duty on April 25, 2013.[3]

On October 27, 2014 OWCP referred appellant, a statement of accepted facts (SOAF) and a series of questions for a second opinion evaluation with Dr. Mark E. Frankel, a Board-certified orthopedic surgeon. In his November 12, 2014 report, Dr. Frankel diagnosed reflex sympathetic dystrophy (RSD) or complex regional pain syndrome (CRPS) due to appellant's accepted employment injury and found that she had not reached maximum medical improvement (MMI). On January 22, 2015 OWCP expanded acceptance of appellant's claim to include RSD of the right upper extremity.

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

In a June 9, 2016 development letter, OWCP requested additional medical evidence supporting that her accepted conditions were permanent and stationary as well as an impairment rating pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4]

[3] On June 18, 2014 appellant filed a notice of recurrence (Form CA-2a) alleging that since her original injury on October 25, 2011 she had experienced continuous pain in the right index finger. She attributed her current condition of chronic pain and reflex sympathetic dystrophy (RSD) to her accepted October 25, 2011 employment injury. By decision dated September 17, 2014, OWCP denied appellant's recurrence claim. Appellant requested reconsideration on October 14, 2014. By decision dated January 22, 2015, OWCP accepted her recurrence claim.

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

On August 19, 2016 OWCP referred appellant, a SOAF, and a list of questions for a second opinion evaluation with Dr. John R. Klein, a Board-certified orthopedic surgeon. In his December 1, 2016 report, Dr. Klein listed appellant's physical findings including numbness on the ulnar aspect of the second finger and on the radial aspect of the third finger. He found no evidence of temperature asymmetry or skin color changes. Dr. Klein reported edema, but no sweating asymmetry. He found slightly decreased range of motion (ROM) of the index finger with flexion and weakness of the intrinsic muscles. Dr. Klein also reported that appellant's bone scan was consistent with RSD. Applying the diagnosis-based impairment (DBI) estimates of the A.M.A., *Guides* for CRPS found in Table 15-24 he noted that based on Table 15-25 at least six points were positive. Dr. Klein assigned a grade modifier for functional history (GMFH) as 3, a grade modifier for physical examination (GMPE) as 2, and noted that a grade modifier for clinical studies (GMCS) were confirmatory for CRPS and concluded that the grade would be C after applying the net adjustment formula. He determined that appellant had reached MMI and had a right upper extremity permanent impairment rating of 25 percent.

On December 30, 2016 OWCP referred Dr. Klein's report to Dr. David I. Krohn, a Board-certified internist serving as a district medical adviser (DMA). In his January 27, 2016 report, the DMA requested additional information from Dr. Klein, including the diagnostic criteria points from Table 15-25 and the basis upon which he had reached his assignment of grade modifiers.

On February 10, 2017 OWCP again referred appellant to Dr. Klein for a follow up examination. On March 23, 2017 Dr. Klein reexamined appellant and referred to Table 15-24, page 453 of the A.M.A., *Guides* which lists the four criteria for a diagnosis of CRPS. He opined that appellant met these criteria as she had continuing pain which was disproportionate to the inciting event. Dr. Klein further found one symptom in three of the listed categories; sensory through hyperesthesia and allodynia, vasomotor through skin color changes and skin color asymmetry, and decreased ROM in the involved hand. He noted that appellant did not have sudomotor or edema changes. Dr. Klein also reported at least one sign in two categories including; sensory through allodynia to light touch, vasomotor changes through skin color changes and asymmetry, and motor/tropic changes through decreased range of motion and motor dysfunction or weakness in the intrinsic muscles. Finally, he found that there was no other diagnosis that better explained the signs and symptoms. Dr. Klein also found that appellant met the diagnostic criteria for CRPS as outlined in Table 15-25, page 453 of the A.M.A., *Guides*. He listed vasomotor changes including skin color changes, tropic changes including skin texture that was smooth and nonelastic, soft-tissue atrophy, and joint stiffness as well as radiographic signs through the bone scan consistent with CRPS. Dr. Klein a GMFH of 2 due to pain and symptoms with normal activity and medication.[5] He found GMPE of 2 due to pain and moderate decreased ROM.[6] Dr. Klein determined that as appellant's bone scan was positive for CRPS, her GMCS was 2.[7] He determined that appellant had a class 2 moderate impairment due to CRPS under Table 15-26, page 454 of the

[5] A.M.A., *Guides* 406, Table 15-7.

[6] *Id.* at 408, Table 15-8.

[7] A.M.A., *Guides* 410, Table 15-9.

A.M.A., *Guides*. Dr. Klein concluded that appellant had grade E or 25 percent impairment of the right upper extremity.

In a March 31, 2017 addendum, Dr. Klein repeated his determination of the grade modifiers and applied the A.M.A., *Guides*' net adjustment formula to reach zero or a combined 20 percent permanent impairment of the right upper extremity.

In a May 5, 2017 report, the DMA found that Dr. Klein had not responded to his prior requests. He determined that appellant had not met the diagnostic criteria for CRPS as Dr. Klein listed only three points from Table 15-25, dry skin, skin texture, and consistent bone scan when a minimum of four criteria were needed to qualify for a CDX of 1 under Table 15-26, page 454.

On June 12, 2017 OWCP again referred appellant for follow-up evaluation with Dr. Klein. In an August 1, 2017 report, Dr. Klein opined that appellant met the diagnostic criteria for CRPS listed in the A.M.A., *Guides*, Table 15-24, page 453, including disproportionate pain, one symptom in three of the four listed categories, as well as one sign in two or more of the categories listed in the A.M.A., *Guides*, Table 15-25, page 453, including edema, increased temperature, and decreased ROM. He found that there was no other diagnosis that better explained her condition. Dr. Klein listed appellant's points consistent with CRPS as required in A.M.A., *Guides*, Table 15-25 including edema, joint stiffness, positive bone scan, smooth nonelastic skin texture, and soft-tissue atrophy. He applied A.M.A., *Guides*, Table 15-26, page 454, and concluded that she had 20 percent permanent impairment of the right upper extremity.

In a September 28, 2017 report, the DMA accepted Dr. Klein's diagnosis of CRPS. However, he found discrepancies between Dr. Klein's physical examinations on March 3, 2017 and December 1, 2016. The DMA requested an additional second opinion evaluation to determine appellant's permanent impairment for schedule award purposes. On January 3, 2018 OWCP expanded acceptance of appellant's claim to include CRPS of the right upper extremity.

On January 15, 2018 OWCP referred appellant for a second opinion evaluation with Dr. Michael A. Steingard, an osteopath Board-certified in orthopedic surgery. In a February 2, 2018 report, Dr. Steingard found no evidence of vasomotor changes and normal hair pattern, but dorsal hyperalgesia in the index, middle, and thumb area of the right hand. He found loss of ROM in the digits and tenderness in the thenar aspect of the right thumb. Dr. Steingard reported positive Froment's sign and decreased motor strength on the right. He found edema in the right hand and that appellant's right hand was cooler than the left. Dr. Steingard noted that appellant's positive objective findings included the bone scan. He diagnosed CRPS, RSD, and that she had initially sustained an open wound with infection. Dr. Steingard determined that appellant had CRPS I based on sensory hyperesthesia, edema, and hyperalgesia in accordance with Table 15-24 page 453 of the A.M.A., *Guides*. He also found under Table 15-25, page 453, appellant had edema, dystrophic changes of soft tissue atrophy at the tips of her fingers, joint stiffness, and positive bone scan. Dr. Steingard determined that in accordance with Table 15-26 page 454 of the A.M.A., *Guides* appellant had mild class 1 CRPS of only four points with default grade C of seven percent permanent impairment. He found moderate problems on physical examination as appellant had a lack of grip or grade 2, he found a GMCS of 1. After applying the net adjustment formula, Dr. Steingard opined appellant had 13 percent permanent impairment rating of the right upper extremity due to CRPS. He listed the date of MMI as February 12, 2014. Dr. Steingard noted that

he did not use range of motion rating because appellant had full ROM although she reported stiffness.

In a July 18, 2018 report, the DMA agreed with Dr. Steingard's application of the A.M.A., *Guides* and determined that appellant had 13 percent permanent impairment of the right upper extremity. He found that as Dr. Frankel had suggested further treatment, appellant was not at MMI by the date of Dr. Frankel's last examination. The DMA further noted that there were differences between Dr. Klein's findings on physical examination and those of Dr. Steingard indicating ongoing improvement. He determined that the date of MMI was February 2, 2018, the date of Dr. Steingard's report as by that point no further improvement was likely from either additional medical or surgical treatment.

By decision dated July 27, 2018, OWCP granted appellant a schedule award for 13 percent permanent impairment of the right upper extremity. It found February 2, 2018 was the date of MMI and found that the period of the award was for 40.56 weeks, from February 2 through November 12, 2018.

LEGAL PRECEDENT

The schedule award provision of FECA[8] and its implementing regulations 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. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[9] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[10]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[11] In addressing impairment for the upper extremities, the sixth edition of the A.M.A., *Guides* requires identifying the impairment class for the diagnosed condition, which is

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404 (1999); *D.S.*, Docket No. 19-0292 (issued June 21, 2019); *Jacqueline S. Harris*, 54 ECAB 139 (2002).

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

[11] A.M.A., *Guides* 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement (6th ed. 2009).

then adjusted by GMFH, GMPE, and GMCS.[12] Evaluators are directed to provide rationale for their impairment rating choices, including the choices of diagnosis from regional grids and calculations of modifier scores.[13]

Impairment due to CRPS is evaluated under the scheme found in Table 15-26 (Complex Regional Pain syndrome (UEI)) as well as Table 15-24 and Table 15-25 and the accompanying relevant text.[14] The grade modifier level (ranging from zero to four) are described from the categories of functional history, clinical studies, and physical examination. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a class rating value. If that class number is not supported by the objective diagnostic criteria point, the highest class specified by those points is selected.[15] The rating for CRPS is a "stand alone" approach.[16]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish greater than 13 percent permanent impairment of the right upper extremity, for which she previously received a schedule award.

OWCP referred appellant for second opinion evaluations with Drs. Klein and Steingard. In accordance with its procedures, it properly referred the reports of these physicians to its DMA, Dr. Krohn, who determined that Dr. Klein properly confirmed appellant's diagnosis of CRPS, but that his reports provided conflicting physical findings and inconsistent correlation with the A.M.A., *Guides*. Dr. Klein initially reported that appellant had no vasomotor changes, but later, on March 23, 2017, he found vasomotor changes as well as providing varying evaluations of appellant's skin changes and soft tissue atrophy. His evaluation of appellant's permanent impairment also varied and was inconsistent with A.M.A., *Guides*. The Board therefore finds that Dr. Klein's reports lack probative value and are insufficient to establish appellant's permanent impairment for schedule award purposes.[17]

The Board finds that the DMA properly requested an additional second opinion evaluation. The DMA reviewed Dr. Steingard's February 2, 2018 report and determined that it provided sufficient findings and a correct application of the A.M.A., *Guides*. He determined that appellant's date of MMI was February 2, 2018, the date of Dr. Steingard's report, as by that point no further

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

[13] *D.S.*, *supra* note 8; *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[14] A.M.A., *Guides* 450-54.

[15] A.M.A., *Guides* 452. The A.M.A., *Guides* provided that if an individual has grade modifiers that ultimately resulted in assignment to class 2 but the objective diagnostic criteria points were only four, the individual would be assigned to class 1, and the physician may muse clinical judgment to decrease or increase the grade within the assigned class and must explain in detail the rationale for any adjustments.

[16] *Id.*

[17] *E.A.*, Docket No. 14-0834 (issued September 16, 2014).

improvement was likely. The DMA explained that Dr. Frankel had suggested further treatment, and that there were differences between Dr. Klein's findings on physical examination and those of Dr. Steingard. Dr. Krohn found that appellant had 13 percent impairment of the right upper extremity due to CRPS.

The Board finds that the DMA described how he arrived at his conclusion by listing appropriate tables and pages in the A.M.A., *Guides*, establishing that appellant sustained 13 percent permanent impairment of the right upper extremity. The DMA's opinion represents the weight of the medical evidence and establishes that appellant does not have greater than 13 percent permanent impairment of each upper extremity previously awarded. Thus, the Board finds appellant has not met her burden of proof to establish that she is entitled to an additional schedule award.

The Board further finds that there is no current medical evidence of record, in conformance with the sixth edition of the A.M.A., *Guides*, establishing that appellant has more than 13 percent permanent impairment of the right upper extremity. Accordingly, appellant has not established entitlement to a schedule award greater than that previously awarded.

Appellant may request a schedule award or increased schedule award at any time based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish greater than 13 percent permanent impairment of the right upper extremity, for which she previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the July 27, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 16, 2019
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board