United States Department of Labor
Employees' Compensation Appeals Board

O.F., Appellant	)	
and	)	**Docket No. 19-0986**
	)	**Issued: February 12, 2020**
U.S. POSTAL SERVICE, SAN FRANCISCO PROCESSING & DISTRIBUTION CENTER, San Francisco, CA, 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 April 4, 2019 appellant filed a timely appeal from a March 4, 2019 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 March 4, 2019 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 more than six percent permanent impairment of her right upper extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On August 19, 2013 appellant, then a 61-year-old mail-processing clerk, filed an occupational disease claim (Form CA-2) alleging that her repetitive employment duties caused right hand and arm injuries. She did not stop work. Following an initial denial on October 1, 2013 by decision dated March 28, 2014, OWCP vacated the October 1, 2013 decision and accepted the claim for right trigger finger, right carpal tunnel syndrome, and right tenosynovitis of hand/wrist. Appellant retired from the employing establishment effective December 31, 2016.

On May 1, 2018 appellant filed a schedule award claim (Form CA-7). In support of her claim, she submitted a February 28, 2018 report in which Dr. Michael E. Hebrard, a Board-certified physiatrist, indicated that appellant's employment-related conditions continued but, as she was not interested in surgical intervention, she was at maximum medical improvement (MMI). Dr. Hebrard diagnosed right trigger finger, right carpal tunnel syndrome, and other synovitis and tenosynovitis, right. He described examination findings noting full range of motion (ROM) of the forearms and fingers with paresthesias in the median and ulnar nerve distributions bilaterally and positive Tinel and Finkelstein tests at the wrists bilaterally. Dr. Hebrard advised that, in accordance with Table 15-3, Hand and Wrist Regional Grid, of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[3] appellant had a class 1 impairment for a diagnosis of right de Quervain's tenosynovitis. He applied grade modifiers of 4 for functional history and 2 for physical examination and concluded that appellant had two percent permanent impairment of the right upper extremity. In a treatment note dated April 12, 2018, Dr. Hebrard reported appellant's continuing complaints including right upper extremity pain with triggering of digits.[4]

On May 14, 2018 OWCP referred the case record to Dr. Michael M. Katz, an OWCP district medical adviser (DMA) who is Board-certified in orthopedic surgery. In a May 18, 2018 report, the DMA noted his review of Dr. Hebrard's impairment evaluation. He noted that, if the A.M.A., *Guides* allowed for use of range of motion (ROM) for the diagnoses in question, impairment was to be calculated using both the ROM and diagnosis-based impairment (DBI) methods and the higher rating was to be identified.

The DMA provided an assessment utilizing the DBI method, finding that under Table 15-3, for a diagnosis of de Quervain's tenosynovitis, appellant had a class 1 impairment with a default value of one percent. He applied the net adjustment formula, finding an adjustment of 1, for a total two percent permanent impairment of the right upper extremity due to de Quervain's tenosynovitis. For a diagnosis of stenosing tenosynovitis (trigger finger) of the right thumb, right

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

[4] Dr. Hebrard provided additional treatment notes, but did not submit an additional impairment evaluation.

middle finger, and right ring finger with persistent triggering, under Table 15-2, Digit Regional Grid, appellant had a class 1 impairment with a default value of six percent for each digit. The DMA found zero adjustments and concluded that appellant had six percent permanent impairment each for thumb, middle, and ring triggering which, under Table 15-12, converted to two percent right hand impairment for the thumb, and one percent impairments for the middle and ring fingers, for a total of four percent right hand impairment, which converted into four percent permanent impairment of the right upper extremity. Dr. Katz further noted that the A.M.A., *Guides* caution that if it was clear to the evaluator that the claimant had loss of ROM, three independent ROM measurements should be documented and the greatest ROM should be used for the determination of impairment. However, if the medical evidence of record was not sufficient to render a rating based on ROM where allowed, an explanation should be given. He determined that the A.M.A., *Guides* permitted the use of the ROM method under Table 15-2 and Table 15-3 but that Dr. Hebrard indicated that appellant had full ROM of all involved joints. The DMA concluded that, therefore, appellant had no ROM impairment. He explained that his right upper extremity permanent impairment rating was higher than that of Dr. Hebrard because Dr. Hebrard described, but did not rate appellant's three trigger finger impairments. The DMA concluded that the date of MMI was "April 11, 2018," the date of Dr. Hebrard's examination.

By decision dated March 4, 2019, OWCP granted appellant a schedule award for six percent right upper extremity permanent impairment, for 8.72 weeks compensation, to run from April 11 to August 20, 2018. It accorded the weight of the medical evidence to the DMA.

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 for loss or loss of use, of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter that rests in the discretion of OWCP. OWCP evaluates the degree of permanent impairment according to the standards set forth in the sixth edition of the A.M.A., *Guides*, published in 2009.[7] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[8]

In addressing upper extremity impairments, the sixth edition requires identification of the impairment class of diagnosis (CDX), which is then adjusted by functional history (GMFH),

[5] *Supra* note 1.

[6] 20 C.F.R. § 10.404.

[7] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used, *supra* note 3. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[8] *H.K.*, Docket No. 18-0528 (issued November 1, 2019).

physical examination (GMPE), and clinical studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[9]

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.[10] 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.[11] 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.[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 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.)[13]

The Bulletin further advises: "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]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to its DMA for an opinion concerning the nature and percentage of impairment

[9] *Supra* note 3 at 411.

[10] *Id*. at 461.

[11] *Id*. at 473.

[12] *Id*. at 474.

[13] FECA Bulletin No. 17-06 (issued May 8, 2017); *see also R.C.*, Docket No. 19-1350 (issued December 11, 2019).

[14] *Id*.

in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[15]

ANALYSIS

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

In his February 28, 2018 report, Dr. Hebrard, appellant's attending physiatrist, provided an impairment evaluation and advised that she was at MMI. He diagnosed trigger finger, carpal tunnel syndrome, and other synovitis and tenosynovitis, and advised that appellant had full ROM of forearms and fingers. Dr. Hebrard indicated that under Table 15-3, for a diagnosis of de Quervain's tenosynovitis, appellant had a class 1 impairment that has a default value of one percent.[16] He then applied the net adjustment formula and concluded that appellant had two percent right upper extremity impairment for this diagnosis. Although Dr. Hebrard submitted additional treatment notes, he did not submit an additional impairment evaluation.[17]

In his May 14, 2018 report, Dr. Katz, the DMA, noted his agreement with Dr. Hebrard regarding the two percent permanent impairment for de Quervain's tenosynovitis. He, however, also noted the diagnosis of triggering finger and provided impairment analyses under Table 15-2 for triggering of the thumb, middle, and ring fingers, indicating that appellant had class 1 impairment of each impacted digit that had a default value of six percent. The DMA found no adjustments and, in accordance with Table 15-12,[18] properly converted the digit impairments to hand impairments, finding two percent permanent thumb impairment added to one percent permanent impairment each of the middle and ring fingers. He properly explained that the total of four percent permanent impairment of the hand converted to four percent permanent impairment of the upper extremity, and when combined with the two percent permanent impairment of the upper extremity due to the de Quervain's tenosynovitis, appellant had a total of six percent permanent impairment of the right upper extremity. The DMA further noted that, as Dr. Hebrard found full ROM of all involved joint, appellant had no ROM impairment and explained that his impairment rating was higher than Dr. Hebrard's because he further evaluated the trigger finger diagnoses.[19]

The Board finds that OWCP properly found that the impairment ratings by the DMA constituted the weight of the medical evidence.[20] The DMA properly applied the appropriate tables and grading schemes to the A.M.A., *Guides* based on Dr. Hebrard's clinical and physical

[15] Federal (FECA) Procedure Manual, *supra* note 7 at Chapter 2.808.6(d) (March 2017).

[16] A.M.A., *Guides*, *supra* note 3 at 395.

[17] *Supra* note 4.

[18] A.M.A., *Guides*, *supra* note 3 at 421.

[19] The Board notes that Dr. Hebrard also did not rate appellant's accepted right carpal tunnel syndrome.

[20] *K.J.*, Docket No. 19-0901 (issued December 6, 2019).

examination findings. He explained that his rating was higher because he also rated appellant's three trigger digits described by Dr. Hebrard, but not rated. There is no probative medical evidence of record demonstrating greater impairment than that previously awarded. Therefore, the Board finds that the record does not establish entitlement to an increased schedule award.[21]

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 permanent impairment.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the March 4, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 12, 2020
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

[21] *Id*.