United States Department of Labor
Employees' Compensation Appeals Board

G.J., Appellant	)	
and	)	**Docket Nos. 19-1651 & 20-0199**
	)	**Issued: June 22, 2020**
DEPARTMENT OF THE ARMY, WOMACK ARMY MEDICAL CENTER, Fort Bragg, NC, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
CHRISTOPHER J. GODFREY, Deputy Chief Judge
PATRICIA H. FITZGERALD, Alternate Judge

JURISDICTION

On July 31, 2019 appellant filed a timely appeal from a July 5, 2019 merit decision of the Office of Workers' Compensation Programs (OWCP). This appeal was docketed as 19-1651. On November 4, 2019 appellant filed a timely appeal from an August 15, 2019 merit decision of OWCP. This appeal was docketed as 20-0199. 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 5 and August 15, 2019 decisions, OWCP received additional evidence. Appellant also submitted additional evidence with his appeal to the Board. 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.*

ISSUES

The issues are: (1) whether appellant has met his burden of proof to establish more than 16 percent permanent impairment of the right upper extremity, for which he previously received a schedule award; and (2) whether appellant has met his burden of proof to establish more than six percent permanent impairment of the right lower extremity, for which he previously received a schedule award.

FACTUAL HISTORY

This case has previously been before the Board.[3] The facts and circumstances as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On April 26, 1994 appellant, then a 51-year-old nursing assistant, filed a traumatic injury claim (Form CA-1) alleging an injury on April 23, 1994 when he struck his right elbow against a piece of equipment while in the performance of duty. OWCP assigned OWCP File No. xxxxxx556 and accepted the claim for right elbow contusion. It authorized right lateral humeral tendon debridement with exploration, which occurred on February 21, 1995. Appellant returned to limited-duty work on April 15, 1995.

On July 20, 1995 appellant filed a Form CA-1 alleging that on July 13, 1995 he injured his right hip when he tripped and fell in the performance of duty. OWCP assigned this claim, OWCP File No. xxxxxx141, and accepted the claim for right hip contusion, right trochanteric bursitis, and right lateral epicondylitis. Appellant stopped work on the date of injury. OWCP paid appellant compensation on the supplemental rolls beginning August 28, 1995 and the periodic rolls beginning June 16, 2002. OWCP File Nos. xxxxxx556 and xxxxxx141 have been administratively combined with the latter serving as the master file.

By decision dated December 23, 1999, OWCP granted appellant a schedule award for 16 percent permanent impairment of the right upper extremity, under OWCP File No. xxxxxx141.

On August 3, 2018 appellant filed a claim for an additional schedule award (Form CA-7).

In a development letter dated October 9, 2018, OWCP advised appellant that additional medical evidence was necessary to establish his schedule award claim. Appellant was requested to submit a report from his treating physician which provided a permanent impairment rating pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4]

Memorandum of telephone calls (Form CA-110) dated November 21 and December 21, 2018 indicate that appellant informed OWCP that he could not obtain a rating report from his

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[3] Docket No. 19-1103, *Order Dismissing Appeal* (issued May 28, 2019).

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

treating physician. Appellant requested that OWCP schedule a second opinion evaluation to assist with the development of his schedule award claim.

On February 19, 2019 OWCP referred appellant for a second opinion evaluation with Dr. Robert M. Moore, a Board-certified orthopedic surgeon, to determine the extent of his permanent impairment, if any, due to the accepted conditions.

In a March 12, 2019 report, Dr. Moore noted appellant's history of injury and medical treatment. He reported that examination of appellant's right upper extremity revealed full active range of motion (ROM) of his elbow, wrist, and hand. Dr. Moore related three ROM findings of appellant's right elbow noting that appellant had flexion of 140 degrees, extension of 0 degrees, pronation of 80 degrees, and supination of 80 degrees. Appellant had no elbow swelling, no sensory deficit, no atrophy, intact right upper extremity motor strength, and exacerbated right elbow pain with restricted wrist extension. Dr. Moore applied the diagnosis-based impairment (DBI) rating methodology of the A.M.A., *Guides.* Using Table 15-4,[5] he noted a default value for the accepted right lateral epicondylitis of five percent.[6] Dr. Moore then assigned a grade modifier for functional history (GMFH) of 2, a grade modifier for physical examination (GMPE) of 0, and a grade modifier for clinical studies (GMCS) of 0.[7] Application of the net adjustment formula[8] resulted in movement one space to the left of the default value on Table 15-4 to the value of four percent permanent impairment. Therefore, Dr. Moore concluded that appellant had four percent permanent impairment of the right upper extremity due to the accepted condition of right lateral epicondylitis.

Regarding the right hip, Dr. Moore indicated that appellant's examination revealed right trochanteric tenderness, no visible swelling or atrophy. He conducted right hip ROM examinations three times and found the maximum ROM to be 10 degrees of flexion contracture, 90 degrees flexion, 20 degrees internal rotation, 30 degrees external rotation, 30 degrees abduction, and 10 degrees adduction. Appellant reported right lumbar pain at the end ranges of right hip motion. A review of appellant's right hip x-ray showed no abnormality and no evidence of dislocation, joint cartilage space narrowing, fracture, soft tissue calcification, osteophyte formation or lytic lesion. Dr. Moore applied the DBI method for rating permanent impairment as it provided a greater impairment rating than using ROM. Using Table 16-4,[9] he noted a default value for the accepted right hip trochanteric bursitis with document chronically abnormal gait of seven percent. Dr. Moore then assigned a grade modifier for GMPE of 1 and a grade modifier for GMCE of 0.[10] He found GMFH was not applicable because gait abnormality was used for primary placement in

[5] *Id.* at 399, Table 15-4.

[6] *Id.*

[7] *Id.* at 406, Table 15-7; 408, Table 15-8; 410, Table 15-9.

[8] *Id.* at 411.

[9] *Id.* at 512.

[10] *Id.* at 516, Table 16-7; 519, Table 16-8.

the regional grid and, thus was not used in adjusting impairment.[11] Application of the net adjustment formula[12] resulted in movement one space to the left of the default value on Table 16-4 to the value of six percent permanent impairment. Therefore, Dr. Moore concluded that appellant had six percent permanent impairment of the right lower extremity due to the accepted condition of right hip trochanteric bursitis.[13]

On April 17, 2019 OWCP referred the claim to a district medical adviser (DMA) for a review of the medical evidence of record and an opinion regarding the extent of appellant's permanent impairment.

On April 20, 2019 Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a DMA, reviewed the medical evidence of record and concluded that appellant had four percent permanent impairment of the right upper extremity and six percent permanent impairment of the right lower extremity. He found, using the ROM methodology for rating permanent impairment of the right upper extremity, that appellant had zero percent permanent impairment as he had full range of motion. The DMA concurred with Dr. Moore's application of the A.M.A., *Guides* in determining appellant's permanent impairment pursuant to the DBI methodology and affirmed that appellant had four percent permanent impairment of the right upper extremity. Regarding permanent impairment of appellant's right lower extremity, the DMA noted that the ROM method for rating permanent impairment could only be used as a stand-alone rating when the impairment could not be rated under the DBI method or if a severe injury resulted in a passive ROM or amputation. However, appellant's permanent impairment could be rated using the DBI method. He concurred that appellant had six percent permanent impairment of the right lower extremity pursuant to Table 16-4, page 512 of the A.M.A., *Guides* for the diagnosis of trochanteric bursitis.

On May 21, 2019 OWCP requested that the DMA clarify whether appellant's current 4 percent permanent impairment of the right upper extremity was in addition to the 16 percent permanent impairment, for which he had previously received a schedule award. In a report dated May 25, 2019, the DMA clarified that appellant's current four percent permanent impairment rating was not an additional impairment.

By decision dated July 5, 2019, OWCP denied appellant's request for an additional schedule finding that the medical evidence did not warrant an increase from the prior schedule award. It noted that he was previously awarded 16 percent permanent impairment of the right upper extremity. OWCP found that the medical evidence of record was insufficient to establish that he was entitled to an additional schedule award as a result of his accepted lateral epicondylitis.

By decision dated August 15, 2019, OWCP granted appellant a schedule award for six percent permanent impairment of the right lower extremity. The award ran for 17.28 weeks for the period March 12 to July 10, 2019.

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[11] *Id.* at 512, 516.

[12] *Supra* note 8.

[13] Dr. Moore determined that the date of maximum medical improvement (MMI) was March 12, 2019 the date of the physical examination he conducted.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA,[14] and its implementing regulations,[15] 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.[16] However, FECA does not specify the manner in which the percentage of loss 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.[17] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[18] The sixth edition requires identifying the class of diagnosis (CDX), which is then adjusted by grade modifiers GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[19]

Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides:

> "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).
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> "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.)
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> "If the rating physician provided an assessment using the DBI method and the [A.M.A.,] *Guides* allow for use of ROM for the diagnosis in question, the DMA

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[14] 5 U.S.C. § 8107.

[15] 20 C.F.R. § 10.404.

[16] *Id.*

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

[18] *Id.*

[19] *Supra* note 4 at 411.

should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE.

"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 necessary to complete the rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence."[20]

ANALYSIS -- ISSUE 1

The Board finds that appellant has not met his burden of proof to establish more than 16 percent permanent impairment of the right upper extremity, for which he previously received a schedule award.

Regarding appellant's right upper extremity, has OWCP accepted that appellant sustained the conditions of right elbow contusion and right lateral epicondylitis. OWCP authorized right lateral tendon debridement with exploration, which was performed on February 21, 1995.

OWCP referred appellant for a second opinion evaluation with Dr. Moore and in his March 12, 2019 report, he found that appellant had reached MMI due to his accepted conditions. He determined that, under the DBI method for rating permanent impairment, utilizing Table 15-4,[21] appellant had a default value of five percent for the accepted right lateral epicondylitis.[22] Dr. Moore then assigned a GMFH of 2, a GMPE of 0, and a GMCS of 0.[23] After applying the net adjustment formula,[24] he concluded, that the net adjustment value would move one space to the left of the default value on Table 15-4, resulting in a permanent impairment finding of four percent. He also provided three ROM measurements of appellant's right elbow, which did not record any loss of ROM.

In accordance with its procedures, OWCP properly referred the evidence of record to Dr. Harris, a DMA, who reviewed the clinical findings of Dr. Moore on April 20, 2019 and determined that appellant had four percent permanent impairment of the right upper extremity based upon Dr. Moore's report and the A.M.A., *Guides*. Dr. Harris explained that appellant had no permanent impairment based upon his ROM findings and therefore his permanent impairment was rated utilizing the DBI method. He found that appellant had reached MMI as of March 12, 2019, the date of Dr. Moore's report.

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

[21] *Id.* at 399, Table 15-4.

[22] *Id.*

[23] *Id.* at 406, Table 15-7; 408, Table 15-8; 410, Table 15-9.

[24] *Id.* at 411.

The Board finds that the DMA discussed how he arrived at his conclusion by listing specific tables and pages in the A.M.A., *Guides*. He accurately summarized the relevant medical evidence, provided detailed findings on examination, and reached conclusions about appellant's conditions which comported with his findings.[25] The DMA properly utilized the DBI method and ROM method to rate appellant's right shoulder condition pursuant to FECA Bulletin No. 17-06. The Board finds that the DMA's report is detailed, well rationalized, and based on a proper factual background.[26] Therefore, his opinion is afforded the weight of the medical evidence and supports that appellant does not have a greater right upper extremity impairment than the 16 percent previously awarded.[27]

There is no current medical evidence of record, in conformance with the sixth edition of the A.M.A., *Guides*, establishing that appellant has greater than the 16 percent permanent impairment of the right upper extremity previously awarded. Accordingly, appellant has not met his burden of proof to establish that he is entitled to an additional schedule award.

LEGAL PRECEDENT -- ISSUE 2

In determining permanent impairment of the lower extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the lower extremity to be rated. With respect to the hip, the relevant portion of the leg for the present case, reference is made to Table 16-4 (Hip Regional Grid) beginning on page 512.[28] After the CDX is determined from the Hip Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[29]

ANALYSIS -- ISSUE 2

The Board finds that appellant has not met his burden of proof to establish more than six percent permanent impairment of his right lower extremity, for which he previously received a schedule award.

As noted above, OWCP referred appellant for a second opinion evaluation with Dr. Moore to determine the degree of appellant's permanent impairment for schedule award purposes. Dr. Moore applied the DBI method for rating permanent impairment, as it provided a greater rating of permanent impairment than the ROM method. Using Table 16-4,[30] he noted a default value for the accepted right hip trochanteric bursitis with documented chronically abnormal gait of seven

[25] *M.D.,* Docket No. 20-0007 (issued May 13, 2020).

[26] *M.S.,* Docket No. 19-1011 (issued October 29, 2019).

[27] *R.R.,* Docket No. 17-1947 (issued December 19, 2018).

[28] *Supra* note 4 at 509-11.

[29] *Id.* at 515-22.

[30] *Id.* at 512.

percent. Dr. Moore then assigned a GMPE of 1 and a GMCE of 0.[31] He found that a GMFH was not applicable because gait abnormality was used for primary placement in the regional grid and, thus was not to be used in adjusting impairment.[32] Application of the net adjustment formula[33] resulted in movement one space to the left of the default value on Table 16-4 to the value of six percent permanent impairment. Thus, Dr. Moore concluded that appellant had six percent permanent impairment of the right lower extremity due to the accepted condition of right hip trochanteric bursitis.

In accordance with its procedures, OWCP referred the evidence of record to a DMA, Dr. Harris, who reviewed the clinical findings of Dr. Moore and determined appellant had six percent permanent impairment of the right lower extremity. He further determined that appellant's date of MMI was March 12, 2019, the date of Dr. Moore's examination upon which his impairment rating was based. Dr. Harris concurred with Dr. Moore that appellant's most impairing diagnosis was chronic trochanteric bursitis. He also explained that the A.M.A., *Guides* did not allow a ROM stand-alone rating if an appropriate DBI could be rated, and the injury was not severe and did not result in amputation. Therefore appellant's permanent impairment was rated under the DBI method. The Board finds that as the DMA's report is detailed, well rationalized, and based on a proper factual background, his opinion represents the weight of the medical evidence.[34] Thus, the Board finds that appellant has not met his burden of proof to establish greater right lower extremity permanent impairment.

The Board 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 six percent permanent impairment of the right lower extremity. Accordingly, appellant has not met his burden of proof to establish 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 his burden of proof to establish more than 16 percent permanent impairment of his right upper extremity, for which he previously received a schedule award. The Board further finds that he has not met his burden of proof to establish more than six percent permanent impairment of his right lower extremity, for which he previously received a schedule award.

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[31] *Id.* at 516, Table 16-7; 519, Table 16-8.

[32] *Id.* at 512, 516.

[33] *Supra* note 8.

[34] *Supra* note 26.

ORDER

IT IS HEREBY ORDERED THAT the August 15 and July 5, 2019 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: June 22, 2020
Washington, DC

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

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

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board