United States Department of Labor
Employees' Compensation Appeals Board

G.G., Appellant	)	
and	)	**Docket No. 21-0134**
	)	**Issued: January 28, 2022**
DEPARTMENT OF THE ARMY, UNITED STATES MILITARY ACADEMY, West Point, NY, 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
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On November 2, 2020 appellant filed a timely appeal from an October 20, 2020 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 met his burden of proof to establish greater than four percent permanent impairment of the right middle finger, for which he previously received a schedule award.

[1] 5 U.S.C. § 8101 *et seq*.

FACTUAL HISTORY

On March 18, 2010 appellant, then a 58-year-old maintenance mechanic, filed a traumatic injury claim (Form CA-1) alleging that on that date he fractured his right middle finger when a three-inch steel pipe that he was loading onto a rack at work slipped and fell onto his right hand. He stopped work on the date of injury, returned to full-time, limited-duty work on March 24, 2010, and was released to full-time, full-duty work on May 13, 2010. On April 27, 2010 OWCP accepted appellant's claim for comminuted fracture of the third distal phalanx.

On March 15, 2011 appellant filed a claim for compensation (Form CA-7) for a schedule award.

OWCP, in an August 8, 2011 development letter, requested that appellant submit a medical report from his attending physician, which addressed whether he had reached maximum medical improvement (MMI) and, if so, to evaluate permanent impairment in accordance with the standards 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 requested information. No additional evidence was received.

By decision dated February 6, 2012, OWCP denied appellant's schedule award claim, finding that he had not established permanent impairment of a scheduled member or function of the body in accordance with the A.M.A., *Guides*. It noted that he had not submitted medical evidence in response to its August 8, 2011 development letter.

On February 27, 2012 appellant requested reconsideration.

By decision dated March 6, 2012, OWCP denied appellant's request for reconsideration of the merits of his claim pursuant to 5 U.S.C. § 8128(a).

OWCP thereafter received medical evidence, including reports dated November 26, 2012 through February 4, 2014, by Dr. Surinder P. Jindal, an attending Board-certified neurologist, who addressed appellant's right middle finger and right hand conditions.

By decision dated March 4, 2014, OWCP again denied appellant's schedule award claim, finding that the medical evidence of record was insufficient to establish permanent impairment of a scheduled member or function of the body as a result of his accepted March 18, 2010 employment injury. It noted that Dr. Jindal had failed to provide a permanent impairment rating based on the sixth edition of the A.M.A., *Guides*.

On April 28, 2014 appellant requested reconsideration.

By decision dated May 7, 2014 decision, OWCP denied appellant's request for reconsideration of the merits of his claim pursuant to 5 U.S.C. § 8128(a).

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

On August 23, 2016 appellant resubmitted a copy of his March 15, 2011 Form CA-7 claim. In response, OWCP, by development letter dated September 2, 2016, again advised appellant of the type of medical evidence needed to establish his schedule award claim. It afforded him 30 days to submit the requested evidence.

OWCP received an additional report dated by Dr. Jindal who continued to note appellant's right middle finger and hand conditions.

In an October 5, 2016 decision, OWCP continued to deny appellant's schedule award claim as the medical evidence of record failed to provide a permanent impairment rating based on the A.M.A., *Guides*.

On October 17, 2016 and February 6, 2017 appellant again requested reconsideration.

By decisions dated January 13 and February 24, 2017, OWCP denied appellant's requests for reconsideration of the merits of his claim pursuant to 5 U.S.C. § 8128(a).

OWCP subsequently received an additional report dated July 5, 2019 by Dr. Jindal. Dr. Jindal noted that he examined appellant on June 5, 2019. He diagnosed displaced fracture of the right middle finger distal phalanx. Dr. Jindal used the range of motion (ROM) rating method found in the sixth edition of the A.M.A., *Guides* and determined that appellant had two percent permanent impairment of his right middle finger. He also determined that appellant had 20 percent "regional impairment" due to loss of use of his right hand due to his right middle finger fracture of the distal phalanx.

On November 19, 2019 Dr. Morley Slutsky, a Board-certified occupational medicine physician, serving as a district medical adviser (DMA), reviewed a statement of accepted facts (SOAF) and the medical record, including Dr. Jindal's July 5, 2019 findings and electromyogram/nerve conduction velocity (EMG/NCV) studies of the right wrist which were performed on June 23, 2017. He determined that appellant had three percent permanent impairment of his right upper extremity under the sixth edition of the A.M.A., *Guides*. Utilizing the diagnosis-based impairment (DBI) rating method, the DMA determined that the most impairing diagnosis for appellant's right middle finger was fracture of the distal phalanx, which was a class of diagnosis (CDX) of 1 with a default value of C or six percent permanent impairment. He noted that Dr. Jindal found two percent permanent impairment of the right middle finger due to loss of ROM and 20 percent permanent impairment of the right upper extremity despite the absence of documented valid ROM measurements and calculations in support of his impairment ratings. The DMA advised that digit impairment was the correct level of impairment as only one digit was involved and this did not extend into the hand. He related that he did not have a copy of Dr. Jindal's June 5, 2019 clinical note in which he used his examination findings of appellant's right middle finger to rate permanent impairment of the finger. The DMA requested to review Dr. Jindal's June 5, 2019 report. He applied Table 15-2 to determine that appellant had six percent impairment of the middle finger. The DMA then determined, based on Table 15-12, that the six percent right middle finger impairment rating converted into one percent permanent impairment of the right upper extremity. The DMA assigned a grade modifier for functional history (GMFH) of 1 under Table 15-7 on page 406 because appellant was still symptomatic. He assigned a grade modifier for physical examination (GMPE) of 1 under Table 15-8 on page 408 based on his

examination findings. The DMA indicated that a grade modifier for clinical studies (GMCS) was not applicable as clinical studies were used to establish the diagnosis. Using the net adjustment formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), he calculated that appellant had a net adjustment of (1-1) + (1-1) + (1-1) = 0, which resulted in a grade C or one percent permanent impairment of the right middle finger. The DMA also provided an impairment rating for appellant's preexisting nonwork-related right carpal tunnel syndrome (CTS), explaining that the preexisting condition affected his right upper extremity permanent impairment. He determined that he had two percent permanent impairment of his right upper extremity due to CTS. The DMA referred to Table 15-23 (Entrapment/Compression Neuropathy Impairment) on page 449, and assigned a grade modifier 1 for GMFH, GMPE, and GMCS. He averaged the grade modifiers to find a default value of two percent. The DMA noted that a *Quick*DASH score was not performed as appellant had mild findings and, thus, had a mild functional score. He concluded that appellant had two percent permanent impairment of his right upper extremity. The DMA utilized the Combined Values Chart on page 604 to combine the one percent impairment rating for a fractured right middle finger and two percent impairment rating for CTS and concluded that appellant had three percent permanent impairment of his right upper extremity. He advised that appellant had reached MMI on July 5, 2019, the date of Dr. Jindal's impairment evaluation.

OWCP, in a December 10, 2019 letter, requested that Dr. Jindal review Dr. Slutsky's findings and provide an addendum report.

In reports dated December 16, 2019, February 27, and March 26, 2020, Dr. Jindal discussed examination findings and provided clinical impressions of neuropathic myofascial pain, paresthesia, and fracture of distal phalanx of right middle finger.

On May 8, 2020 DMA Dr. Slutsky reviewed Dr. Jindal's June 5, 2019 and February 27 and March 26, 2020 reports and noted that there was no significant change in the clinical findings in these three evaluations. He determined that, based on the DBI method, appellant's right middle finger fracture of the distal phalanx was a CDX of 1 with a default value of C or four percent permanent impairment. The DMA noted that this was a change from his prior finding of six percent permanent impairment because he had accidently read the wrong column in Table 15-2 on page 393 for appellant's diagnosis. Using Table 15-12 on page 421, he converted the four percent right middle finger impairment to one percent impairment of the right upper extremity. The DMA reiterated why Dr. Jindal's two percent right middle finger permanent impairment rating due to loss of ROM and 20 percent permanent impairment of the right upper extremity were not acceptable under the A.M.A., *Guides*. He reiterated his prior calculations based on a diagnosis of preexisting nonwork-related right CTS and concluded that appellant had two percent right upper extremity permanent impairment. The DMA again used the Combined Values Chart on page 604 to combine the one percent right middle finger impairment rating and two percent impairment rating for CTS and concluded that appellant had three percent permanent impairment of his right upper extremity. He determined that appellant reached MMI on June 5, 2019, the date of Dr. Jindal's impairment evaluation.

By decision dated October 20, 2020, OWCP granted appellant a schedule award for four percent permanent impairment of the right middle finger. The award ran for one week from June 5 through 11, 2019 and was based on the May 8, 2020 impairment rating of DMA Dr. Slutsky.

LEGAL PRECEDENT

It is the claimant's burden of proof to establish permanent impairment of a scheduled member or function of the body as a result of an employment injury.[3]

The schedule award provisions of FECA[4] and its implementing regulations[5] 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. 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 to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be 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.[6] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (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]

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): A Contemporary Model of Disablement.[9] Under the sixth edition, the evaluator identifies the CDX, which is then adjusted by grade modifiers of GMFH, GMPE, and GMCS.[10] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[11]

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

[3] *See T.H.*, Docket No. 19-1066 (issued January 29, 2020); *D.F.*, Docket No. 18-1337 (issued February 11, 2019); *Tammy L. Meehan*, 53 ECAB 229 (2001).

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id*. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[7] *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).

[8] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[9] *Supra* note 2 at page 3, section 1.3(a).

[10] *Id*. at 494-531.

[11] *Id*. at 411.

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.,] *Guide*s 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.)

"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 should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the [claims examiner] 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 DMA method, if possible, given the available evidence."[12]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with OWCP's DMA providing rationale for the percentage of impairment specified.[13]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish greater than four percent permanent impairment of the right middle finger for which he previously received a schedule award.

In support of his schedule award claim, appellant submitted a July 5, 2019 report from Dr. Jindal who noted that he examined appellant on June 5, 2019 and found two percent permanent impairment due to a diagnosis of displaced fracture of the right middle finger distal phalanx under the ROM methodology set forth in the sixth edition of the A.M.A., *Guides* and 20 percent permanent impairment of the right upper extremity due to loss of use of his right hand.

OWCP properly routed Dr. Jindal's report to its DMA, Dr. Slutsky.[14] In a November 19, 2019 report, he utilized the DBI rating method and found that the most impairing diagnosis for

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

[13] *See supra* note 7 at Chapter 2.808.6(f) (March 2017); *see D.J.*, Docket No. 19-0352 (issued July 24, 2020).

[14] *Id*.

appellant's right middle finger was fracture of the distal phalanx, which was a CDX of 1 with a default value of C or six percent permanent impairment. Utilizing Table 15-12 on page 421 (391-94), the DMA converted the six percent right middle finger impairment rating into one percent permanent impairment of the right upper extremity. He assigned grade modifiers and applied the net adjustment formula and found a net adjustment of zero, resulting in no movement from the default value of C and corresponding to a one percent right middle finger permanent impairment. The DMA explained that Dr. Jindal's two percent ROM impairment rating for the right middle finger and 20 percent impairment for the right upper extremity were improper as he failed to document valid ROM measurements and provide calculations and rationale to support his impairment ratings. He noted that digit impairment was the correct level of impairment as only one digit was involved and this did not extend into the hand. The DMA requested to review Dr. Jindal's June 5, 2019 clinical note. He also found that appellant had two percent permanent impairment of his right upper extremity due to his preexisting nonwork-related CTS demonstrated on the June 23, 2017 EMG/NCV study. The DMA explained that he rated this condition because it affected his right upper extremity permanent impairment. He assigned grade modifiers and applied the net adjustment formula and found a net adjustment of zero, resulting in no movement from the default value of C and corresponding to two percent permanent impairment due to right CTS. The DMA referred to the Combined Values Chart on page 604 and determined that appellant had a combined three percent permanent impairment of his right upper extremity.

In a May 8, 2020 supplemental report, the DMA reviewed additional reports by Dr. Jindal, including his missing June 5, 2019 report, and found no significant change in Dr. Jindal's clinical findings. He again utilized the DBI method under Table 15-2 on page 393, and determined that appellant's right middle finger fracture of the distal phalanx was a CDX of 1 with a default value of C or four percent permanent impairment of the right middle finger. The DMA related that his four percent impairment rating differed from his prior six percent right middle finger impairment rating because he had accidently read the wrong column in Table 15-2 for appellant's diagnosis.

The Board finds that the DMA's opinion constitutes the weight of the medical evidence with respect to the permanent impairment of appellant's right middle finger because he properly applied the appropriate standards of the A.M.A., *Guides*.[15] Thus, appellant has not met his burden of proof.

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 his burden of proof to establish greater than four percent permanent impairment of the right middle finger for which he previously received a schedule award.

[15] *See O.F.*, Docket No. 19-0986 (issued February 12, 2020); *M.C.*, Docket No. 15-1757 (issued March 17, 2016) (the DMA's opinion constituted the weight of the medical evidence as his report was the only one of record that demonstrated a proper application of the A.M.A., *Guides*).

ORDER

IT IS HEREBY ORDERED THAT the October 20, 2020 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 28, 2022
Washington, DC

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

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

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