United States Department of Labor
Employees' Compensation Appeals Board

K.K., Appellant	)	
and	)	**Docket No. 23-0745**
	)	**Issued: February 1, 2024**
U.S. POSTAL SERVICE, HICKSVILLE POST OFFICE, Hicksville, NY, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On April 29, 2023 appellant filed a timely appeal from an April 25, 2023 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 greater than five percent permanent impairment of his right upper extremity (right arm), for which he previously received a schedule award.

FACTUAL HISTORY

On September 9, 2021 appellant, then a 38-year-old postal inspector (A1), filed a traumatic injury claim (Form CA-1) alleging that on August 30, 2021 he developed pain in his neck, left

[1] 5 U.S.C. § 8101 *et seq*.

triceps, and right forearm/elbow area when arresting a violently resisting suspect while in the performance of duty. OWCP accepted the claim for temporary aggravation of lateral epicondylitis, right elbow. It subsequently expanded its acceptance of appellant's claim to include lateral epicondylitis, right elbow, and extensor carpi radialis brevis (ECRB) tendon tear with low-grade partial biceps tear, right.

On October 3, 2022 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In support of his claim, appellant submitted a July 29, 2022 report from Dr. Michael J. Angel, a Board-certified orthopedic surgeon, diagnosing right elbow lateral epicondylitis with ECRB tearing status post debridement and tendon reattachment. Dr. Angel indicated that appellant had reached maximum medical improvement (MMI) on that date and provided findings on physical examination of no swelling, erythema, ecchymosis, abrasions, or edema. He measured range of motion (ROM) of the right elbow of 5 to 120 degrees. Dr. Angel found that appellant was neurovascularly intact with one centimeter of atrophy and four plus strength. Dr. Angel found 17.5 percent impairment due to appellant's severe lateral epicondylitis with mild loss of range of motion.

In an October 5, 2022 development letter, OWCP requested that appellant submit an impairment evaluation addressing whether he had reached MMI and providing an impairment rating using 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.

Thereafter, OWCP received a January 27, 2022 operative report from Dr. Angel noting a diagnosis of right elbow lateral epicondylitis/ECRB tendon tear. He described the right elbow lateral epicondylar debridement with tendon reattachment that he performed on appellant.

In a November 2, 2022 note, Dr. Angel indicated that he had diagnosed appellant with right elbow lateral epicondylitis with ECRB tearing status post debridement and tendon reattachment, and status postsurgical debridement with tendon repair performed on January 27, 2022. He indicated a date of MMI of July 29, 2022, the date of appellant's last office visit.

On November 8, 2022 OWCP referred the medical record and a statement of accepted facts (SOAF) to Dr. Michael M. Katz, an OWCP District Medical Adviser (DMA) and Board-certified orthopedic surgeon, to determine the extent of appellant's permanent impairment due to his accepted employment-related conditions.

In a November 16, 2022 report, Dr. Katz utilized the sixth edition of the A.M.A., *Guides*[3] and rated appellant's upper extremity permanent impairment. He found that appellant had reached MMI on July 29, 2022, and provided both diagnosis-based impairment (DBI) and range of motion (ROM) based ratings, concluding that appellant had five percent impairment of the right upper

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

[3] *Id*.

extremity. Dr. Katz first applied the DBI methodology, relying on Dr. Angel's examination findings, and utilized the Elbow Regional Grid set forth in Table 15-4 on page 398-400. He assigned a class of diagnosis (CDX) for epicondylitis, lateral or medial, status postsurgical release with residual symptoms a Class 1 impairment, with a default value of five percent. Using Table 15-7, Table 15-8, and Table 15-9 on pages 406-10, Dr. Katz assigned a grade modifier for functional history (GMFH) of 1 and a grade modifier for physical examination (GMPE) of 1, based on his review of the medical records. He indicated that the grade modifier for clinical studies (GMCS) could not be utilized and then applied the net adjustment formula set forth on page 411, (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (1 - 1) + (1 - 1) + (NA) = 0, to find no net adjustment from the default value. Dr. Katz concluded that appellant had five percent impairment for the right upper extremity based on the DBI method.

Applying the ROM method, Dr. Katz explained that the A.M.A., *Guides* permitted an alternative calculation when decreased ROM was present and used Table 15-33, page 474. He relied on Dr. Angel's July 29, 2022 physical examination measurements of right elbow of flexion of 120 degrees and extension of zero degrees. Using Table 15-35, page 477, Dr. Katz assigned a grade modifier of 3 for range of motion and, using Table 15-7, page 406, assigned a grade modifier of 3 for functional history. He noted that Dr. Angel provided only a single set of motion measurements that resulted in a ROM impairment rating of three percent, which was less than the DBI impairment rating. Dr. Katz explained that additional sets of ROM measurements could only further decrease appellant's ROM impairment rating because the best effort result would be used in the calculation. Thus, he related that incorporating three sets of ROM measurements would not improve appellant's ROM impairment rating because, even if a worse range of motion was observed, the current value still would be used as the best value in the calculation; further, if a better range of motion was measured, that measurement would only decrease appellant's ROM impairment rating, which would remain lower than the DBI rating. As the DBI impairment rating yielded a higher value than the ROM rating, Dr. Katz submitted the DBI impairment calculation of five percent as his recommendation. He cited to FECA Bulletin No. 17-06 as a reference.[4]

In a December 12, 2022 letter, OWCP requested that Dr. Angel clarify his July 29, 2022 report and explain whether he used the sixth edition of the A.M.A., *Guides*, provide any tables or grids used, and comment on Dr. Katz' November 16, 2022 report.

Thereafter, OWCP received an amended version of Dr. Angel's July 29, 2022 report which was identical to his original report, except that the 17.5 percent impairment figure was changed to 7.5 percent, due to severe lateral epicondylitis with mild loss of range of motion. Dr. Angel indicated that the calculation was based on "the Workers' Compensation November 2017."

On February 15, 2023 OWCP referred appellant, along with the case record and a SOAF, to Dr. Leon Sultan, a Board-certified orthopedic surgeon, for a second opinion examination and rating of permanent impairment using the sixth edition of the A.M.A., *Guides*.

In a March 21, 2023 report, Dr. Sultan reviewed the SOAF, the medical record, and the history of injury, and reported the findings of his physical examination. He noted no complaints of palpation on the right elbow soft tissues or bony structures, a firm grip on the right side with

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

intact pinch mechanism, and normal sensory testing of the right upper extremity. Dr. Sultan recorded ROM of appellant's right elbow using goniometric measurements and tested movements three times, using the best measurements in his calculations. On three occasions, appellant's right elbow extension lacked three degrees, flexion was 140 degrees, pronation was 90 degrees from neutral, and supination was 90 degrees from neutral. Dr. Sultan diagnosed status post right elbow lateral epicondylitis and ECRB tendon tear resolved through surgery. Using Table 15-4 on page 399 of the sixth edition of the A.M.A., *Guides*,[5] he utilized a CDX of lateral right elbow epicondylitis and found that appellant's impairment was a Class 1 with a GMFH of 1, a GMPE of 1, and a GMCS of 1, resulting in a DBI of grade C and a final upper extremity impairment of one percent. Dr. Sultan indicated a date of MMI of March 21, 2023, the date of his examination.

On April 12, 2023 OWCP again referred the medical record and SOAF to Dr. Katz, in his role as DMA, to review Dr. Sultan's March 21, 2023 report and determine the extent of appellant's permanent impairment.

In an April 16, 2023 supplemental report, Dr. Katz reviewed the medical record and SOAF and provided impairment ratings using Table 15-4, page 399 of the sixth edition of A.M.A., *Guides*.[6] He assigned a Class 1 impairment for a CDX of epicondylitis, lateral or medial, status postsurgical release with residual symptoms, and assigned the default value of five percent. Using Table 15-7, Table 15-8, and Table 15-9, page 406-10, Dr. Katz indicated grade modifier adjustments as follows: a GMFH of 1; a GMPE of 1; and with GMCS not applicable. After applying the net adjustment formula, he noted that these values resulted in an increase of zero from the default value C, which equaled Class 1 impairment, grade C, with a default value of five percent impairment. Dr. Katz related that the A.M.A., *Guides* only permitted an alternative ROM calculation in situations where decreased ROM is present and that Dr. Sultan's physical examination found normal ROM in appellant's right arm, thus, there was no calculable ROM impairment and he relied on the DBI method. He also indicated that he believed that Dr. Sultan used an incorrect factor in his calculation when he used a one percent value for the CDX of epicondylitis, lateral or medial with residual symptoms, which did not reflect the fact that surgical release/debridement/reattachment had been performed. Dr. Katz explained that the alternative CDX that he used above, which had a default value of five percent, was the correct factor. He assigned a date of MMI of July 29, 2022, the date of Dr. Angel's examination.

By decision dated April 25, 2023, OWCP granted appellant a schedule award for five percent permanent impairment of the right arm. The period of the award ran for 15.6 weeks from July 29 through November 15, 2022.

[5] *Id*.

[6] *Id*.

LEGAL PRECEDENT

The schedule award provisions of FECA[7] and its implementing federal regulations[8] 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, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants.[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 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.[11]

In addressing upper extremity impairments, the sixth edition requires that the evaluator identify the impairment CDX, which is then adjusted by a 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 methodology is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other DBI 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 added.[15] 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.[16]

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology *versus* the ROM methodology for rating of upper extremity impairments.[17] Regarding the application of

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] *Id*. at § 10.404(a).

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

[11] *D.P.*, Docket No. 20-1330 (issued February 19, 2021); *D.S.*, Docket No. 18-1140 (issued January 29, 2019); *Isidoro Rivera*, 12 ECAB 348 (1961).

[12] A.M.A., *Guides* 383-492.

[13] *Id*. at 411.

[14] *Id*. at 461.

[15] *Id*. at 473.

[16] *Id*. at 474.

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

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

> "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.)[18]

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 [claims examiner]."[19]

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]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the percentage of permanent impairment using the A.M.A., *Guides*.[21]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish greater than five percent permanent impairment of his right upper extremity (right arm), for which he previously received a schedule award.

In a November 16, 2022 report, Dr. Katz referred to the sixth edition of the A.M.A., *Guides* and found that appellant had reached MMI on July 29, 2022. He first applied the DBI methodology, relying on Dr. Angel's examination findings, and utilized the Table 15-4 on page 398-400. Dr. Katz assigned CDX for epicondylitis, lateral or medial, status postsurgical release with residual symptoms, Class 1 impairment with a default value of five percent. Using Table 15-7, Table 15-8, and Table 15-9, page 406-10, he assigned GMFH of 1 and a GMPE of 1. Dr. Katz

[18] A.M.A., *Guides* 477.

[19] FECA Bulletin No. 17-06 (issued May 8, 2017); *A.H.*, Docket No. 23-0335 (issued July 28, 2023); *V.L.*, Docket No. 18-0760 (issued November 13, 2018); *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

[20] *Id.*

[21] *Supra* note 10 at Chapter 2.808.6f (March 2017); *D.S.*, Docket No. 20-0670 (issued November 2, 2021); *B.B.*, Docket No. 18-0782 (issued January 11, 2019).

indicated that the GMCS could not be utilized and then applied the net adjustment formula, finding no adjustment from the default value of grade C, which resulted in five percent impairment for the right upper extremity based on the DBI method.

Applying the ROM method, Dr. Katz used Table 15-33, page 474, and relied on Dr. Angel's July 29, 2022 right elbow physical examination measurements of flexion of 120 degrees and extension of 0 degrees. Using Table 15-35, page 477, he assigned a grade modifier of 3 for ROM and, using Table 15-7, page 406, assigned a grade modifier of 3 for functional history. Dr. Katz noted that Dr. Angel provided only a single set of motion measurements that resulted in a ROM impairment rating of three percent and explained that additional sets of ROM measurements could only further decrease appellant's ROM impairment rating because the best effort result would be used in the calculation. Thus, because the DBI impairment rating yielded a higher value than the ROM rating, Dr. Katz submitted the DBI impairment calculation of five percent as his recommendation.[22]

Subsequently, OWCP referred appellant to Dr. Sultan for an impairment evaluation. On March 21, 2023 Dr. Sultan found that appellant had normal sensation of the right upper extremity with a firm grip, intact pinch mechanism, and no pain on palpation of the right elbow. He measured ROM of the right elbow as normal. Dr. Sultan identified CDX of lateral right elbow epicondylitis, which he found yielded a default impairment of one percent. He applied grade modifiers and found no change from the one percent permanent impairment rating for the right upper extremity.

In his April 16, 2023 supplemental report, Dr. Katz again reviewed the medical record and SOAF and provided impairment ratings using Table 15-4, page 398 of the sixth edition of A.M.A., *Guides*.[23] He assigned a Class 1 impairment for the CDX of epicondylitis, lateral or medial, status postsurgical release with residual symptoms, with a default value of five percent. Using Table 15-7, Table 15-8, and Table 15-9, page 406-10, Dr. Katz indicated net adjustments as GMFH of 1, GMPE of 1, with GMCS as not applicable. After applying the net adjustment formula, he noted that these values resulted in an increase of zero from the default value C, which equaled a Class 1 impairment, with a default Grade C, or five percent impairment. Dr. Katz related that the A.M.A., *Guides* only permits an alternative ROM calculation in situations where decreased ROM is present and Dr. Sultan's physical examination found normal ROM in the right arm, thus, there was no calculable ROM impairment and he relied on the DBI method. He indicated that Dr. Sultan used an incorrect CDX in his calculation when he assigned one percent impairment for the CDX of epicondylitis, lateral or medial with residual symptoms, which did not reflect the fact that surgical release/debridement/reattachment had been performed. Dr. Katz explained that the alternative CDX that he used above, which resulted in a default value of five percent, was the correct factor. He assigned a date of MMI of July 29, 2022, the date of Dr. Angel's examination.

The Board finds that OWCP properly relied on the opinion of Dr. Katz, the DMA, to find that appellant had no greater than five percent permanent impairment of his right upper extremity

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

[23] *Id*.

(right arm). Dr. Katz reached conclusions regarding appellant's permanent impairment that are in accordance with the standards of the sixth edition of the A.M.A., *Guides*.

Appellant submitted an amended July 29, 2022 report from Dr. Angel, an attending physician, who determined that he had 7.5 percent permanent impairment of the right upper extremity due to severe lateral epicondylitis with mild loss of range of motion. However, the Board finds that this report is of limited probative value because Dr. Angel failed to provide detailed findings or adequate explanation of whether his conclusions were derived in accordance with the sixth edition of the A.M.A., *Guides*. The Board has held that an opinion on permanent impairment is of limited probative value if it is not derived in accordance with the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses.[24]

As appellant has not established greater than five percent permanent impairment of his right upper extremity (right arm), for which he previously received a schedule award, the Board finds that he 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 five percent permanent impairment of his right upper extremity (right arm), for which he previously received a schedule award.

[24] *See T.S.*, Docket No. 22-0924 (issued April 27, 2023); *N.A.*, Docket No. 19-0248 (issued May 17, 2019); *James Kennedy, Jr.*, 40 ECAB 620 (1989) (finding that an opinion which is not based upon the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of a claimant's permanent impairment).

ORDER

IT IS HEREBY ORDERED THAT the April 25, 2023 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 1, 2024
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board