United States Department of Labor
Employees' Compensation Appeals Board

T.J., Appellant	)	
and	)	**Docket No. 13-751**
	)	**Issued: July 3, 2013**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Mountain Home, TN, Employer	)	

Appearances:
George Todd East, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On February 11, 2013 appellant filed a timely appeal from a September 13, 2012 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 more than a permanent impairment of 20 percent right arm, 13 percent left arm and 13 percent to both legs.

FACTUAL HISTORY

On May17, 2005 appellant, then a 39-year-old nurse, filed a traumatic injury claim (Form CA-1) alleging that on April 28, 2005 she injured her right elbow when she was lifting a hand table. OWCP initially accepted the claim for lateral epicondylitis of the right elbow. On

[1] 5 U.S.C. § 8101 *et seq.*

November 16, 2005 the claim was accepted for reflex sympathetic dystrophy (RSD) of the right arm. Upon additional development of the medical evidence, on March 28, 2007, OWCP accepted pain disorders related to psychological factors. After further development, on January 16, 2009 OWCP accepted RSD to both arms and legs.

In a report dated April 17, 2009, Dr. Scott Dulebohn, a neurosurgeon, stated that according to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* appellant was 100 percent disabled in all four extremities. OWCP prepared a statement of accepted facts and referred the case to a Dr. Jonathan Turoff for a second opinion evaluation.

By report dated August 14, 2009, Dr. Turoff provided a history and results on examination. He diagnosed complex regional pain syndrome (CRPS) of both upper and lower extremities. Dr. Turoff opined that appellant had a 100 percent impairment under the A.M.A., *Guides*. He indicated that appellant had a *Quick*DASH score of 41 and cited Table 15-39.[2]

In a report dated August 28, 2009, an OWCP medical adviser stated that Dr. Turoff had accepted a range of subjective complaints, but the A.M.A., *Guides* had objective diagnostic criteria for CRPS. He stated that, based on the objective criteria noted by Dr. Turoff, appellant had a class 1 impairment under Table 15-26. The medical adviser opined that appellant had a 13 percent impairment to each extremity.

By decision dated December 2, 2009, OWCP issued a schedule award for a 13 percent permanent impairment to both upper and lower extremities. The period of the award was 156 weeks of compensation commencing November 22, 2009.

Appellant requested a hearing before an OWCP hearing representative, which was held on April 14, 2010. On June 10, 2010 OWCP received a May 28, 2010 report from the employing establishment physician, Dr. Terry Puckett, who provided an opinion under the fifth edition of the A.M.A., *Guides*.

By decision dated June 29, 2010, the hearing representative affirmed the December 2, 2009 OWCP decision. The hearing representative indicated that the weight of the evidence was represented by OWCP's medical adviser.

On January 4, 2011 appellant requested reconsideration of her claim. She submitted a November 17, 2010 report from Dr. William Kennedy, a Board-certified orthopedic surgeon, who provided a history and results on examination. Dr. Kennedy opined that, under the fifth edition of the A.M.A., *Guides*, appellant met the requirements for a CRPS diagnosis. He opined that appellant had a 53 percent right arm impairment, a 36 percent left arm impairment, a 42 percent right leg impairment and a 40 percent left leg impairment.

By decision dated March 23, 2011, OWCP reviewed the case on its merits and denied modification. It noted that the sixth edition of the A.M.A., *Guides* was currently applied to determine the degree of permanent impairment.

[2] *Quick*DASH is a shortened version of the Disabilities of the Arm, Shoulder, and Hand (DASH) questionnaire used to assess functional ability.

Appellant requested reconsideration and submitted a May 6, 2011 report from Dr. Kennedy, who opined that appellant's diagnosis of CRPS was established under the sixth edition of the A.M.A., *Guides*. Dr. Kennedy referred to his prior report with respect to points for objective diagnostic criteria. With respect to the degree of permanent impairment under the sixth edition, he opined that appellant's impairment under the sixth edition was 38 percent for each arm, and 38 percent for each leg, based on application of Table 15-26 and Table 16-15.

OWCP referred the case to an OWCP medical adviser to review. A July 1, 2011 memorandum asked the medical adviser for an opinion as to the right arm permanent impairment. In a July 1, 2011 report, the medical adviser indicated that he disagreed with Dr. Kennedy. He stated that Table 15-25 required radiographic confirmation. According to the medical adviser the right arm impairment was 20 percent under Table 15-26. In a report dated July 11, 2011, the medical adviser indicated that he disagreed with Dr. Kennedy regarding the left arm and both legs. He stated that appellant's complaints and functional limitations were not sufficient to establish a severe impairment without confirming objective findings. According to the medical adviser, appellant had no impairment to the left arm, or legs and a 20 percent right arm impairment.

By decision dated March 23, 2012, OWCP issued a schedule award for an additional seven percent permanent impairment to the right arm. The period of the award was from November 18, 2012 to April 19, 2013. On July 12, 2012 appellant requested reconsideration. She submitted a July 9, 2012 report from Dr. W. Turney Williams, a pain medicine specialist, who provided results on examination and indicated that appellant remained disabled. In a report dated July 26, 2012, an OWCP medical adviser opined that there was no evidence of an additional permanent impairment.

By decision dated September 13, 2012, OWCP reviewed the case on its merits and denied modification. It found that appellant had not established an impairment greater than previously awarded.

LEGAL PRECEDENT

Section 8107 of the FECA provides that, if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[3] Neither FECA nor the regulations specify the manner in which the percentage of impairment for a schedule award shall be determined. For consistent results and to ensure equal justice for all claimants OWCP has adopted the American Medical Association, *Guides to the Evaluation of Permanent Impairment* as the uniform standard applicable to all claimants.[4] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition.[5]

[3] 5 U.S.C. § 8107. This section enumerates specific members or functions of the body for which a schedule award is payable and the maximum number of weeks of compensation to be paid; additional members of the body are found at 20 C.F.R. § 10.404(a).

[4] *A. George Lampo*, 45 ECAB 441 (1994).

[5] FECA Bulletin No. 09-03 (issued March 15, 2009).

FECA provides that, if there is a disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make the examination.[6] The implementing regulations state that if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[7]

ANALYSIS

In the present case, OWCP accepted RSD to both arms and both legs resulting from an April 28, 2005 lifting incident. It has issued schedule awards for a 20 percent right arm impairment, and 13 percent to the left arm and each leg. The A.M.A., *Guides* notes that RSD is also known as CRPS, and this diagnosis is "a challenging and controversial concept" that "has been a troublesome area for impairment rating."[8] As noted in the A.M.A., *Guides*, "No diagnostic criteria have been uniformly accepted for CRPS, and no laboratory study is considered definitive."[9]

The A.M.A., *Guides* provide specific guidelines for an impairment rating to the upper and lower extremities from CRPS. The diagnosis of CRPS must be confirmed based on the diagnostic criteria provided in Table 15-24 (upper extremity) and Table 16-13 (lower extremity).[10] If the diagnosis is confirmed, the number of objective diagnostic criteria points is determined under Table 15-25 (upper extremity) and Table 16-14 (lower extremity).[11] The impairment is then calculated using Table 15-26 for the arms and Table 16-15 for the legs.[12] The default value is adjusted in accord with grade modifiers for functional history, physical examination and clinical studies.[13]

Dr. Kennedy and an OWCP medical adviser applied the above methodology and disagreed as to the percentage of impairment to each extremity. He found diagnostic criteria points under Table 15-25 and Table 16-14 sufficient to establish a class 3 impairment (severe).

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[6] 5 U.S.C. § 8123.

[7] 20 C.F.R. § 10.321 (1999).

[8] A.M.A., *Guides* 341, 450.

[9] *Id.* at 341.

[10] *Id*. at 453, Table 15-24 and at 539, Table 16-13.

[11] The Board notes that OWCP's medical adviser stated that Table 15-25 required radiographic evidence. Table 15-25 (and its corresponding Table 16-14 for the legs) does not require any specific radiographic evidence. An objective diagnostic criteria point may be found if there are radiographic signs of trophic bone changes, or a bone scan with findings consistent with CRPS. *Id.* at 453.

[12] *Id.* at 454, Table 15-26 and at 541, Table 16-15.

[13] For the upper extremities, *see id*. at 406-11, Table 15-7 to Table 15-10. For the lower extremities, *see id.* at 515-21, Table 16-6 to Table 16-9.

OWCP's medical adviser found the objective criteria sufficient for a class 2 (moderate) impairment to the right arm, and class 1 (mild) for the left arm and both legs.

The Board finds that the case must be remanded to OWCP for selection of a referee physician in accord with 5 U.S.C. § 8123(a). The referee physician should provide a rationalized medical opinion on the issue presented. In this regard OWCP should ensure that the referee applies the proper methodology under the A.M.A., *Guides* as discussed above. After such further development as OWCP deems necessary, it should issue an appropriate decision.

CONCLUSION

The Board finds that a conflict in the medical evidence exists and the case must be remanded for resolution of the conflict.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated September 13, 2012 is set aside and the case remanded for further action consistent with this decision of the Board.

Issued: July 3, 2013
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

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

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board