

**United States Department of Labor
Employees' Compensation Appeals Board**

J.D., Appellant

and

**U.S. POSTAL SERVICE, POST OFFICE,
Chicago, IL, Employer**

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**Docket No. 15-1286
Issued: December 14, 2015**

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

Case Submitted on the Record

DECISION AND ORDER

Before:

CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On May 18, 2015 appellant filed a timely appeal from an April 17, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act¹ (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 established that she sustained ratable bilateral upper extremity impairment.

¹ 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board.² The facts and circumstances outlined in the Board's prior decision are incorporated herein by reference.

OWCP accepted that on or before October 23, 2005 appellant, then a 48-year-old schemed mail distribution clerk, sustained a right rotator cuff tear, herniated C5-6 disc with degenerative disc disease, bilateral carpal tunnel syndrome, de Quervain's tenosynovitis of the right wrist and right radial tenosynovitis. She stopped work on May 11, 2005 and did not return. Appellant received compensation for total disability on the supplemental and periodic rolls.

Dr. Samuel J. Chmell, an attending Board-certified orthopedic surgeon, performed a left median nerve release on April 20, 2006 and a right median nerve release on December 15, 2006. He submitted periodic reports through November 6, 2008 finding appellant totally disabled for work due to bilateral carpal tunnel syndrome, bilateral wrist pain and crepitus, multiple tendinitis in the upper extremities and bilateral shoulder derangement.³

On June 20, 2008 appellant claimed a schedule award for upper extremity impairment. She submitted a July 14, 2008 impairment evaluation from Dr. Chmell utilizing the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, "A.M.A., *Guides*"). Dr. Chmell found 77 percent impairment of the right upper extremity due to limited shoulder motion, weakness, and cervical radiculopathy. He found 40 percent impairment of the left arm due to diminished sensation in the hand and thumb, pain, dysesthesia, and weakness.

On October 8, 2008 OWCP obtained a second opinion from Dr. David H. Trotter, a Board-certified orthopedic surgeon, who opined, under the fifth edition of the A.M.A., *Guides*, that appellant had no permanent impairment of either upper extremity.

By decision dated January 22, 2009, OWCP denied appellant's schedule award claim, finding that the medical evidence did not establish ratable impairment of either extremity. It accorded Dr. Trotter the weight of the medical evidence.

² Docket No. 10-2126 (issued July 5, 2011).

³ On July 30, 2007 OWCP obtained a second opinion from Dr. Hythem P. Shadid, a Board-certified orthopedic surgeon, regarding appellant's work limitations. Dr. Shadid found mild right carpal tunnel syndrome and nonoccupational peripheral neuropathy. He opined that appellant required no injury-related work restrictions and had attained maximum medical improvement. OWCP found a conflict of medical opinion between Dr. Shadid and Dr. Chmell, and selected Dr. Charles W. Mercier, a Board-certified orthopedic surgeon, as impartial medical examiner. Dr. Mercier submitted February 12, 2008 and February 24, 2009 reports finding mild de Quervain's tenosynovitis of the right wrist that did not require any work restrictions.

On February 20, 2009 appellant requested an oral hearing. She submitted progress reports from Dr. Chmell finding no change in her condition.⁴

By decision dated and finalized May 13, 2009, an OWCP hearing representative set aside OWCP's January 22, 2009 decision, finding a conflict of medical opinion between Dr. Trotter, for the government, and Dr. Chmell, for appellant, regarding the appropriate percentage of upper extremity impairment. The hearing representative remanded the case for selection of an impartial medical examiner. Instead, OWCP selected Dr. Rodrigo M. Ubilluz, a Board-certified neurologist, as a second opinion specialist. In a January 29, 2010 letter to appellant, OWCP advised that Dr. Ubilluz was to perform a second opinion evaluation. Dr. Ubilluz provided a March 3, 2010 report finding no ratable impairment of the upper extremities according to the sixth edition of the A.M.A., *Guides*.

By decision dated March 22, 2010, OWCP denied a schedule award as the medical evidence did not establish any permanent impairment of the upper extremities related to the accepted injuries. It accorded Dr. Ubilluz the weight of the medical evidence as the impartial medical examiner. Appellant then appealed to the Board.

By decision and order issued July 5, 2011,⁵ the Board set aside OWCP's March 22, 2010 decision, finding that Dr. Ubilluz could not represent the weight of the medical opinion as he was not an impartial medical examiner. The Board remanded the case to OWCP for selection of an impartial medical specialist to resolve the remaining conflict between Dr. Chmell and Dr. Trotter.⁶

In a February 2, 2012 letter, OWCP advised appellant that it had selected Dr. Jaroslaw Dzwinyk, a Board-certified orthopedic surgeon, an impartial medical examiner. It provided him a copy of the medical record and statement of accepted facts.⁷

In a March 1, 2012 letter, appellant requested to participate in selection of the impartial medical examiner, alleging that Dr. Dzwinyk was biased because he was "charged with a secret

⁴ April 17, 2009 magnetic resonance imaging (MRI) scans of appellant's shoulders showed bilateral supraspinatus, infraspinatus and subscapularis tendinosis with a nodular lesion over the superior left shoulder. An April 20, 2009 MRI scan of the right wrist showed a small ganglion cyst in the carpal tunnel, mild flexor tendon tenosynovitis, possible median nerve edema, a small volar synovial cyst ganglion, minimal tenosynovitis of the extensor carpi radialis longus and brevis tendons, and mild tendinosis and subluxation of the extensor carpi ulnaris tendon. An April 20, 2009 MRI scan of the left wrist showed ganglion cysts at the volar aspect of the radiocarpal joint and flexor pollicis longus tendon, and mild extensor carpi ulnaris tendinosis.

⁵ *Supra* note 2.

⁶ During the pendency of the prior appeal, appellant submitted copies of medical records dating from 1979 through 2011. These records did not include a new impairment rating.

⁷ Appellant remained off work. Dr. Chmell provided a February 20, 2012 letter finding her totally and permanently disabled for work due to bilateral carpal tunnel syndrome and right radial styloid tenosynovitis.

mission” to find no permanent impairment. OWCP responded by March 6, 2012 letter, denying her request finding no valid reason to select a new impartial physician.⁸

Dr. Dzwinyk provided a March 26, 2012 report reviewing the medical record and statement of accepted facts. On examination, he observed multiple pain behaviors, limited cervical spine motion, diffuse tenderness to palpation of the neck and shoulders, and 3/5 give way weakness in the anterior deltoids. Dr. Dzwinyk noted the following ranges of motion for both shoulders: 0 to 180 degrees forward flexion; 0 to 100 degrees abduction; 0 to 120 degrees external rotation; 0 to 80 degrees internal rotation. Tinel’s sign was negative at both elbows, and Finkelstein’s test was negative at both wrists. Bilateral elbow motion was limited by appellant’s muscle guarding and body habitus. Dr. Dzwinyk found subjective, nonanatomic loss of light touch sensation in both hands, with well-healed surgical scars from the median nerve releases. He asserted that appellant’s symptoms were “markedly out of proportion” to the minimal objective findings. Dr. Dzwinyk noted that appellant had full range of motion throughout the upper extremities, with a normal neurologic examination. He noted that appellant had no objective evidence of carpal tunnel syndrome or de Quervain’s tenosynovitis. Also, imaging studies of record did not support a cervical disc herniation, but rather a central bulge. Dr. Dzwinyk opined that there was “no evidence to support any amount of permanent impairment to either of the upper extremities” using the sixth edition of the A.M.A., *Guides*.

By decision dated May 1, 2012, OWCP denied appellant’s schedule award claim, finding that the medical record did not support ratable impairment of the upper extremities, based on Dr. Dzwinyk’s opinion as the weight of the medical evidence. It noted that Dr. Dzwinyk provided detailed, extensive rationale explaining that appellant had no objective findings in either arm.

In a May 26, 2012 letter, appellant requested an oral hearing. She alleged that OWCP did not follow its procedures in selecting Dr. Dzwinyk. Appellant submitted additional medical evidence.

In a March 9, 2012 report, Dr. Robert James Fink, an attending Board-certified orthopedic surgeon, recommended electrodiagnostic testing to rule out right carpal tunnel syndrome and right cubital tunnel syndrome. Dr. Chmell opined on March 21, 2012 that appellant’s bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome, bilateral ulnar neuropathy at the elbows, bilateral brachial plexopathy, and bilateral C3-T1 radiculopathy remained active. In a May 3, 2012 report, he disagreed with Dr. Dzwinyk, noting that numerous electrodiagnostic studies demonstrated objective, ratable upper extremity impairments.

By decision dated August 20, 2012, an OWCP hearing representative set aside the May 1, 2012 decision and remanded the case for referral of Dr. Dzwinyk’s report to an OWCP medical adviser for review, to be followed by issuance of a *de novo* decision.

In an October 29, 2012 report, an OWCP medical adviser reviewed the medical record and the reports of Dr. Trotter and Dr. Dzwinyk. He noted that, although Dr. Trotter and

⁸ Appellant submitted several statements from March through May 2012, as well as copies of medical evidence previously of record, contending that Dr. Dzwinyk was not objective or impartial.

Dr. Dzwinyk did not specify a date of maximum medical improvement, it was “likely to have occurred on May 28, 2005, which [was] two months after the date of the work injury.”

By decision dated January 10, 2013, OWCP denied appellant’s schedule award claim, finding that the medical evidence did not establish that she had ratable impairment of either arm. It accorded the weight of the medical evidence to Dr. Dzwinyk.

In a February 5, 2013 letter, appellant requested an oral hearing. She asserted that an OWCP medical adviser was not authorized to select the date of maximum medical improvement. At the hearing, held June 26, 2013, appellant asserted that she remained totally disabled for work, with pain and paresthesias throughout her neck, back, and all extremities, as well as migraine and cluster headaches.

Following the hearing, appellant provided a May 20, 2013 electromyography (EMG) and nerve conduction velocity (NCV) report of the upper extremities showing mild bilateral carpal tunnel syndrome, with distal sensory latency at 2.75 milliseconds on the right and 3.85 milliseconds on the left. There was no evidence of radiculopathy, plexopathy, or polyneuropathy in either arm.

By decision dated September 11, 2013, an OWCP hearing representative set aside the January 10, 2013 decision, finding that the case required additional medical development. The hearing representative directed that OWCP obtain a supplemental report from Dr. Dzwinyk, based on the May 20, 2013 EMG and NCV report and an updated statement of accepted facts, to be followed by issuance of a *de novo* decision.

In a March 17, 2014 supplemental report, Dr. Dzwinyk reviewed the May 20, 2013 EMG and NCV study. He noted that according to page 487 of the sixth edition of the A.M.A., *Guides*, distal latencies of less than 4.0 milliseconds were considered normal, with no impairment. As appellant’s distal latencies were 2.75 milliseconds on the right and 3.85 milliseconds on the left, both less than 4.0 milliseconds, she did not have any upper extremity impairment due to carpal tunnel syndrome.⁹

An OWCP medical adviser reviewed Dr. Dzwinyk’s supplemental report on May 26, 2014, and concurred with his assessment of zero percent impairment rating of the upper extremities under the sixth edition of the A.M.A., *Guides*. He noted that appellant attained maximum medical improvement as of May 28, 2000.

By decision dated August 14, 2014, OWCP denied appellant’s schedule award claim, finding that the medical evidence did not demonstrate a ratable impairment of either upper extremity. It accorded the weight of the medical evidence to Dr. Dzwinyk.

⁹ Appellant submitted a March 20, 2014 letter from Dr. Chmell, in which he opined that she remained permanently and totally disabled for work due to bilateral carpal tunnel syndrome, right radial styloid tenosynovitis, lumbar derangement, cervical derangements, lumbar radiculopathy, and blunted sensation and weakness throughout the extremities.

In an August 30, 2014 letter, appellant requested an oral hearing. She contended that Dr. Dzwinyk and OWCP's medical adviser mischaracterized Dr. Chmell's findings. At the hearing, held February 11, 2015, appellant contended that OWCP disregarded the medical evidence. She described difficulties with activities of daily living. Following the hearing, appellant submitted a March 4, 2015 statement asserting that the accepted cervical disc herniation caused ratable upper extremity impairment. She also provided March 4, 2015 and April 2, 2015 letters from Dr. Chmell finding that appellant remained totally and permanently disabled for work due to musculoskeletal and neurologic symptoms throughout her spine and extremities.

By decision dated April 17, 2015, an OWCP hearing representative affirmed the August 14, 2014 decision denying appellant's schedule award claim, finding that the medical evidence did not demonstrate a ratable impairment of either upper extremity. The hearing representative accorded the weight of the medical evidence to Dr. Dzwinyk, who presented a thorough, well-reasoned opinion explaining that appellant had no ratable abnormalities in either arm.

LEGAL PRECEDENT

The schedule award provisions of FECA¹⁰ provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. It, 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 which rests in the sound discretion of OWCP. 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. The A.M.A., *Guides* has been adopted by OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.¹¹ For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*.¹²

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).¹³ Under the sixth edition, the evaluator identifies the impairment Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).¹⁴ The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).

¹⁰ 5 U.S.C. § 8107.

¹¹ *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

¹² Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (February 2013); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

¹³ A.M.A., *Guides* 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement" (6th ed. 2008).

¹⁴ *Id.* at 494-531 (6th ed. 2009).

In addressing upper extremity impairments, the sixth edition requires identifying the impairment CDX, which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.¹⁵ The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).¹⁶

No schedule award is payable for a member, function, or organ of the body not specified in FECA or in the regulations.¹⁷ Because neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back,¹⁸ no claimant is entitled to such an award.¹⁹ However, in 1966, amendments to FECA modified the schedule award provision to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. As the schedule award provision of FECA includes the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.²⁰

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 percentage of impairment using the A.M.A., *Guides*.²¹

Section 8123(a) of FECA provides that when there is a disagreement between the physician making the examination for the United States and the physician of the employee, a third physician shall be appointed to make an examination to resolve the conflict.²² When there are opposing medical reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a), to resolve the conflict in the medical evidence.²³

ANALYSIS

OWCP accepted that appellant sustained bilateral carpal tunnel syndrome, a right rotator cuff tear, right radial tenosynovitis, and de Quervain's tenosynovitis of the right wrist. Appellant claimed a schedule award on June 20, 2008 for bilateral upper extremity impairment. Dr. Chmell, an attending Board-certified orthopedic surgeon, provided a July 14, 2008

¹⁵ *Id.* at 385-419; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

¹⁶ *Id.* at 411.

¹⁷ *Henry B. Floyd, III*, 52 ECAB 220 (2001).

¹⁸ FECA specifically excludes the back from the definition of "organ." 5 U.S.C. § 8101(19).

¹⁹ *Thomas Martinez*, 54 ECAB 623 (2003).

²⁰ *See Thomas J. Engelhart*, 50 ECAB 319 (1999).

²¹ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

²² 5 U.S.C. § 8123(a); *Robert W. Blaine*, 42 ECAB 474 (1991).

²³ *Delphia Y. Jackson*, 55 ECAB 373 (2004).

impairment rating based on the fifth edition of the A.M.A., *Guides* then in effect, finding 77 percent impairment of the right upper extremity and 40 percent impairment of the left upper extremity. OWCP obtained second opinion from Dr. Trotter, a Board-certified orthopedic surgeon, who opined on October 8, 2008 that appellant had no ratable impairment of either arm under the fifth edition of the A.M.A., *Guides*. It found a conflict of medical opinion between Dr. Trotter and Dr. Chmell, and selected Dr. Dzwinyk, a Board-certified orthopedic surgeon, to resolve it. OWCP denied the schedule award claim based on Dr. Dzwinyk's report as a weight of the medical evidence. The Board finds that this denial was proper under the facts and circumstances of the case.

Dr. Dzwinyk provided a March 26, 2012 report reviewing the medical record and statement of accepted facts under the sixth edition of the A.M.A., *Guides*. He noted a normal orthopedic and neurologic examination of the upper extremities, remarking that appellant exhibited symptom exaggeration and pain behaviors. Dr. Dzwinyk emphasized that there was no objective evidence of the accepted carpal tunnel syndrome or tenosynovitis. He therefore opined that appellant had no ratable impairment of either arm. An OWCP medical adviser concurred with this assessment. Dr. Dzwinyk provided a March 17, 2014 supplemental report reviewing May 20, 2013 electrodiagnostic studies showing distal latencies in the upper extremities within normal limits. He explained that these minimal findings were not ratable under the appropriate section of the A.M.A., *Guides*. An OWCP medical adviser concurred with Dr. Dzwinyk's opinion on May 26, 2014.

The Board finds that OWCP properly accorded Dr. Dzwinyk's opinion the weight of the medical evidence. Dr. Dzwinyk was clear in his findings and opinions, and provided a detailed explanation as to why the accepted conditions were no longer present or active. His opinion was also based on a complete, accurate factual and medical history. OWCP's April 17, 2015 decision denying a schedule award was therefore proper under the facts and law of this case.

On appeal, appellant asserts a pattern of fraud, dishonesty, and misfeasance by OWCP. In particular, she contends that she should have been granted a schedule award under the fifth edition of the A.M.A., *Guides*, but OWCP deliberately delayed developing the claim until the sixth edition went into effect. The Board has reviewed appellant's contentions, and notes that there is no evidence of impropriety by OWCP.²⁴

Appellant also argued that Dr. Chmell was not given an opportunity to perform an impairment rating. The Board notes that Dr. Chmell performed an impairment rating on July 14, 2008. Dr. Chmell provided periodic reports through April 2, 2015. There is no indication that OWCP prevented him from submitting an updated impairment rating.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

²⁴ T.S., Docket No. 11-2016 (issued May 9, 2012).

CONCLUSION

The Board finds that appellant has not established that she sustained a ratable bilateral upper extremity impairment.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated April 17, 2015 is affirmed.

Issued: December 14, 2015
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board