

condition on August 1, 2010 and he first realized on September 13, 2013 that it was caused or aggravated by his employment. Appellant stopped work on September 9, 2013 and returned to his regular work on October 24, 2013.²

On September 9, 2013 Dr. Charles Mercier, an attending Board-certified orthopedic surgeon, performed surgical excision of appellant's left wrist ganglion cyst with decompression for the de Quervain's condition of the first dorsal exterior compartment of his left wrist.³ On September 20, 2013 Dr. Mercier discussed his follow-up treatment of appellant's left wrist.

OWCP accepted appellant's claim on December 27, 2013 for radial styloid tenosynovitis of his left wrist, ganglion cyst of the synovium, tendon, and bursae of his left wrist.

Appellant filed a claim for a schedule award (Form CA-7) received by OWCP on August 8, 2014. In an August 18, 2014 letter, OWCP requested that he submit a medical report containing an impairment rating for his left upper extremity under the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (6th ed. 2009).

Appellant's case file was reviewed by Dr. David Garelick, a Board-certified orthopedic surgeon serving as an OWCP medical adviser, and he concluded on November 7, 2014 that there was no medical evidence showing that appellant had a permanent impairment of his left upper extremity. Dr. Garelick indicated that it was unclear whether appellant's left wrist condition had reached maximum medical improvement.

By decision dated December 29, 2014, OWCP denied appellant's schedule award claim finding that he had not submitted medical evidence establishing permanent impairment of his left upper extremity under the standards of the sixth edition of the A.M.A., *Guides*.

Appellant, through counsel, requested reconsideration of his claim in a letter received by OWCP on June 24, 2015. He submitted a May 26, 2015 report in which Dr. James P. Elmes, an attending Board-certified orthopedic surgeon, discussed his medical history and reported findings of the physical examination on that date. Dr. Elmes diagnosed left wrist radial tenosynovitis and left wrist ganglion cyst and noted that appellant continued to complain of left wrist pain, particularly with activity. He indicated that, using Table 15-3 on page 395 of the sixth edition of the A.M.A., *Guides*, appellant's diagnosis-based condition of ganglion cyst fell under class 1 (residual symptoms with consistent objective findings) with a default value of two percent. Under the de Quervain's condition diagnosis on Table 15-3, appellant fell under class 1 with a default value of one percent due to residual symptoms without consistent objective findings. For the ganglion cyst condition, Dr. Elmes found a grade modifier for Functional History (GMFH) of 0, grade modifier for Physical Examination (GMPE) of 1, and grade modifier for Clinical Studies (GMCS) of 0. For the de Quervain's condition, he found a GMFH of 0, GMPE of 1, and GMCS of 1. Applying the Net Adjustment Formula to the calculations for

² Appellant did not receive any wage-loss compensation on the daily or periodic compensation rolls. He received continuation of pay for this period off work.

³ This surgical procedure was authorized by OWCP at a later date.

the ganglion cyst and de Quervain's conditions meant that appellant had a one percent permanent impairment of his left upper extremity due to the ganglion cyst condition and a one percent permanent impairment of his left upper extremity due to the de Quervain's condition.⁴ Dr. Elmes added the impairment ratings for the ganglion cyst condition (one percent) and the de Quervain's condition (one percent) and concluded that appellant had a two percent permanent impairment of his left upper extremity. He noted that appellant's left wrist condition had reached maximum medical improvement.

On September 5, 2015 Dr. Michael Hellman, a Board-certified orthopedic surgeon serving as an OWCP medical adviser, reviewed appellant's case file, including the May 26, 2015 report of Dr. Elmes. He noted that, under section 15.3f on page 419 of the sixth edition of the A.M.A., *Guides*, he used the most impairing diagnosis within the region of appellant's left wrist. This diagnosis was appellant's de Quervain's/tenosynovitis condition which, using Table 15-3 on page 395, meant that the condition fell under class 1 with a default value of one percent. For the de Quervain's condition, Dr. Hellman found a GMFH of 0, GMPE of 1, and GMCS of 0. Application of the Net Adjustment Formula required moving two places to the left of the default value on Table 15-3 such that appellant had a total left upper extremity impairment of zero percent. He found that appellant had reached maximum medical improvement by May 26, 2015. Dr. Hellman concluded that he disagreed with Dr. Elmes' impairment rating because Dr. Elmes used two separate diagnoses for appellant's left wrist and added them together, whereas section 15.3f provides that only the most impairing diagnosis is to be used for a given region.

By decision dated September 30, 2015, OWCP denied modification of its December 29, 2014 decision finding that appellant has a zero percent impairment of his left upper extremity. It found that the weight of the medical evidence with respect to appellant's left upper extremity impairment rested with the opinion of Dr. Hellman.

LEGAL PRECEDENT

The schedule award provision of FECA⁵ and its implementing regulations⁶ 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. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.⁷

⁴ See *infra* note 8.

⁵ 5 U.S.C. § 8107.

⁶ 20 C.F.R. § 10.404 (1999).

⁷ See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); see also Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010). For OWCP decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used. *B.M.*, Docket No. 09-2231 (issued May 14, 2010).

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated. With respect to the wrist, the relevant portion of the arm for the present case, reference is made to Table 15-3 (Wrist Regional Grid) beginning on page 395. After the Class of Diagnosis (CDX) is determined from the Wrist 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).⁸

ANALYSIS

OWCP accepted appellant's claim for radial styloid tenosynovitis of his left wrist, ganglion cyst of the synovium, tendon, and bursae of his left wrist.⁹ Appellant filed a claim for a schedule award, but OWCP denied same finding that he had a zero percent impairment of his left upper extremity. OWCP found that the weight of the medical evidence with respect to his left upper extremity impairment rested with the opinion of Dr. Hellman, a Board-certified orthopedic surgeon who served as an OWCP medical adviser. Dr. Hellman had based his impairment rating under the sixth edition of the A.M.A., *Guides* on the May 26, 2015 examination findings of Dr. Elmes, an attending Board-certified orthopedic surgeon.

In a May 26, 2015 report, Dr. Elmes concluded that appellant had two percent permanent impairment of his left upper extremity. He noted that, using Table 15-3 on page 395 of the sixth edition of the A.M.A., *Guides*, appellant's diagnosis-based condition of ganglion cyst fell under class 1 with a default value of two percent. Under the de Quervain's condition diagnosis on Table 15-3, appellant fell under class 1 with a default value of one percent. Dr. Elmes calculated grade modifiers for both appellant's ganglion cyst condition and the de Quervain's condition. Applying the Net Adjustment Formula to the calculations for the ganglion cyst and de Quervain's conditions meant that appellant had a one percent permanent impairment of his left upper extremity due to the ganglion cyst condition and a one percent permanent impairment of his left upper extremity due the de Quervain's condition. Dr. Elmes added the impairment ratings for the ganglion cyst condition (one percent) and the de Quervain's condition (one percent) and concluded that appellant had a two percent permanent impairment of his left upper extremity.

In a September 5, 2015 report, Dr. Hellman concluded that appellant had a zero percent permanent impairment of his left upper extremity. He noted that, under Table 15-3 on page 395, appellant's diagnosis of de Quervain's/tenosynovitis condition for the left wrist meant that the condition fell under class 1 with a default value of one percent. For the de Quervain's condition, Dr. Hellman also calculated grade modifier values. Application of the Net Adjustment Formula required moving two places to the left of the default value on Table 15-3 such that appellant had a total left upper extremity impairment of zero percent.

⁸ See A.M.A., *Guides* (6th ed. 2009) 395-97.

⁹ On September 9, 2013 appellant underwent surgical excision of his left wrist ganglion cyst with decompression for the de Quervain's condition of the first dorsal exterior compartment of his left wrist. This surgery was later authorized by OWCP.

The Board finds that there is a conflict in the medical opinion evidence between Dr. Elmes and Dr. Hellman regarding the extent of the permanent impairment of appellant's left upper extremity. Section 8123(a) of FECA provides in pertinent part: "If there is 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 an examination."¹⁰ When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of FECA, to resolve the conflict in the medical evidence.¹¹

Consequently, the case must be referred to an impartial medical specialist to resolve the conflict in the medical opinion evidence between Dr. Elmes and Dr. Hellman regarding the extent of the permanent impairment of appellant's left upper extremity. On remand OWCP should refer appellant, along with the case file and the statement of accepted facts, to an appropriate specialist for an impartial medical evaluation and report including a rationalized opinion on this matter. After carrying out this development, OWCP should issue a *de novo* decision regarding his schedule award claim.

CONCLUSION

The Board finds that the case is not in posture for decision regarding whether OWCP properly determined that appellant has a zero percent permanent impairment of his left upper extremity. The case is remanded to OWCP for further development.

¹⁰ 5 U.S.C. § 8123(a).

¹¹ *William C. Bush*, 40 ECAB 1064, 1075 (1989).

ORDER

IT IS HEREBY ORDERED THAT the September 30, 2015 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to OWCP for further proceedings consistent with this decision of the Board.

Issued: February 22, 2016
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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