United States Department of Labor
Employees' Compensation Appeals Board

K.D., Appellant	)	
and	)	**Docket No. 11-1600**
	)	**Issued: February 8, 2012**
DEPARTMENT OF HOMELAND SECURITY, TRANSPORTATION SECURITY AGENCY, Phoenix, AZ, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On June 28, 2011 appellant, through counsel, filed a timely appeal from an April 13, 2011 schedule award 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 the schedule award decision.[2]

[1] 5 U.S.C. §§ 8101-8193.

[2] Appellant's counsel indicated that he sought an appeal of an April 28, 2011 OWCP letter that responded to counsel's request to stop appellant's schedule award. OWCP advised counsel of the appeal rights accompanying the April 13, 2011 decision if he disagreed with that decision. No new appeal rights were given with the letter. The Board finds that this was an informational letter and not a final decision of OWCP. Consequently, no appeal can be taken from the April 28, 2011 letter. *See* 20 C.F.R. § 501.2(c) (the Board has jurisdiction over final decisions of OWCP); 20 C.F.R. § 10.126 (notes the contents of a final decision of OWCP).

ISSUE

The issue is whether appellant has established that she has more than 60 percent impairment of the left upper extremity and 1 percent impairment of the right upper extremity for which she received a schedule award.

FACTUAL HISTORY

On August 11, 2005 appellant, then a 46-year-old lead transportation security screener, filed a traumatic injury claim alleging that she tripped and fell over a passenger bag that day, injuring both wrists. OWCP accepted that she sustained a left closed fracture of the radius with ulna, open fracture of unspecified part of radius with ulna, unspecified closed fracture of the lower end of forearm and a right wrist sprain. On August 19, 2005 Dr. Robert Berghoff, a Board-certified orthopedic surgeon, repaired the left distal radius fracture. Appellant briefly returned to modified duty and was placed on the periodic compensation rolls in September 2006.

In a June 25, 2007 report, Dr. Kevin S. Ladin, Board-certified in physiatry and pain medicine, advised that appellant was unable to use her left arm in a functional manner. Following the employment injury, appellant had a complex regional pain syndrome (CRPS) of the left upper extremity that developed into reflex sympathetic dystrophy (RSD), characterized by marked discoloration, mottling, increased sweating, cutaneous allodynia and hyperalgesia of the left upper limb.

Appellant came under the care of Dr. Estelle Farrell, a Board-certified osteopath specializing in physical medicine and rehabilitation. On September 12, 2007 Dr. Farrell diagnosed: CRPS and RSD of the left upper extremity; right upper extremity ulnar neuropathy, possibly primarily sensory with dysfunctional motor use of the extremity; left elbow contracture; mild concentration issues and possible right upper extremity thoracic outlet. Appellant was removed from employment by the employing establishment effective October 9, 2010.

On October 15, 2010 appellant filed a schedule award claim. She submitted a work capacity evaluation dated October 15, 2010 in which Dr. Farrell noted that appellant had a 100 percent impairment of the left arm and a 50 percent impairment on the right.

By letter dated October 22, 2010, OWCP asked that Dr. Farrell provide an impairment rating in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*).[3] In a January 31, 2011 report, Dr. Farrell noted that she had examined appellant on December 14, 2010 and provided an impairment worksheet. She advised that appellant's primary diagnosis was left upper extremity RSD with subsidiary diagnoses of right upper extremity tendinopathy and pain, and reported the Disabilities of the Arm, Shoulder and Hand (DASH) scores of 4,075 on the left and 3,025 on the right. Regarding the left arm, Dr. Farrell advised that, under Table 15-24 and Table 15-26, appellant had a class 3 impairment due to CRPS, with a grade E, for a 49 percent impairment. She found a functional history modifier of 4, a physical examination modifier of 4, and a clinical studies modifier of 3, which she added to the 49 percent default impairment rating, for a final left

[3] A.M.A., *Guides* (6th ed. 2008).

arm impairment of 60 percent. Regarding the right arm, Dr. Farrell advised that, under Table 15-7 and Table 15-8, appellant had a grade C impairment, functional history and clinical modifiers of 3, and a physical examination modifier of 2, for a 30 percent right arm impairment.

By letter dated February 2, 2011, appellant advised OWCP that she did not want to file a schedule award and was withdrawing her claim.

OWCP referred appellant to Dr. Ronald M. Lampert, Board-certified in orthopedic surgery, for a second opinion evaluation. Dr. Lampert was asked to provide an impairment evaluation in accordance with the sixth edition of the A.M.A., *Guides*, for the accepted upper extremity conditions, based on a statement of accepted facts. In a February 2, 2011 report, he reviewed the history of injury and appellant's complaint that her left arm did not function with constant pain and pain in the right upper extremity with any type motion. Dr. Lampert reviewed the medical record and provided physical examination findings. He advised that examination of the right wrist showed normal flexion, extension, and radial and ulnar deviation with good grip strength. Dr. Lampert noted that appellant did not want her left hand or arm touched, and noted that the left wrist was essentially fixed at 30 degrees of flexion with no radial or ulnar deviation and no active motion. He diagnosed ankylosed left wrist and normal right wrist. Dr. Lampert advised that, based on the statement of accepted facts, appellant had no objective evidence of any permanent impairment of the right upper extremity as a result of the employment injury. Based on Table 15-3, Wrist Regional Grid, appellant had a zero percent right upper extremity impairment. Regarding the left upper extremity, Dr. Lampert advised that appellant would not fit into any category for a diagnosis-based impairment and therefore, due to abnormal motion, he rated her under Table 15-32, Wrist Range of Motion. Appellant had a grade 4 modifier due to ankylosis, which yielded a 25 percent left upper extremity impairment. Dr. Lampert advised that the date of maximum medical improvement was February 2, 2011 and attached an impairment worksheet pertaining to his findings. In a supplementary report dated February 8, 2011, he referenced the footnote found on page 497 of the A.M.A., *Guides*, and advised that he used Table 15-3 to rate appellant's left upper extremity impairment because there was abnormal motion, and that no adjustment was made for functional history because of factors that were not included in the statement of accepted facts.

Dr. Farrell submitted additional reports describing appellant's treatment. She stated that appellant's wrist range of motion was restricted, more on the left than right, with normal right grip strength.

On March 28, 2011 Dr. Arthur S. Harris, an OWCP medical adviser and a Board-certified orthopedic surgeon, reviewed the statement of accepted facts and medical record, including the impairment evaluations of Dr. Farrell and Dr. Lampert. He diagnosed status post straining injury of the right wrist; status post percutaneous pinning of a left distal radius fracture; and CRPS of the left upper extremity. In accordance with the sixth edition of the A.M.A., *Guides*, under Table 15-3, appellant had a one percent impairment of the right upper extremity for residual problems. Under Table 15-26, she had a 60 percent left upper extremity impairment for residual problems with CRPS. Dr. Harris noted that Dr. Lampert did not take CRPS into account in his impairment evaluation and agreed with Dr. Farrell's impairment finding for the left upper extremity. He noted that Dr. Farrell did not document any significant loss of motion to support her finding of a

30 percent right upper extremity impairment, and therefore appellant only had a 1 percent right upper extremity impairment.

In an April 13, 2011 decision, appellant was granted schedule awards for 60 percent impairment of the left and 1 percent impairment of the right arm. The awards ran from April 10, 2011 to December 2, 2014. OWCP advised that the schedule awards were payable consecutively but not concurrently with wage-loss compensation.

LEGAL PRECEDENT

The schedule award provision of FECA,[4] and its implementing federal 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[6] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* was used to calculate schedule awards.[7] For decisions issued after May 1, 2009, the sixth edition is to be used.[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).[9] Under the sixth edition, the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with OWCP's medical adviser providing rationale for the percentage of impairment specified.[11]

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[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id.* at § 10.404(a).

[7] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (January 2010).

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

[9] A.M.A., *Guides*, *supra* note 2 at 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

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

[11] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

ANALYSIS

The Board finds this case is not in posture for decision. Regarding appellant's left upper extremity, it is unclear whether CRPS has been accepted as employment related. If it is a subsequently acquired condition, unless it has been accepted as consequential to the employment injury, it could not form the basis for a schedule award.[12] Dr. Farrell, the attending physiatrist, and Dr. Harris, OWCP's medical adviser, based their left upper extremity impairment rating on physical findings for this condition. The only statement of accepted facts in the case record is dated May 1, 2006. The record does not contain a copy of the statement of accepted facts forwarded to Dr. Lampert, who provided a second opinion evaluation or to Dr. Harris. Moreover, the evaluations of both physicians on CRPS do not comport with section 15.5 of the A.M.A., *Guides*. Dr. Farrell indicated that she utilized Table 15-24 and Table 15-26 in rating appellant at 60 percent left upper extremity impairment. Table 15-24 provides the diagnostic criteria for CRPS.[13] Other than generally referencing Table 15-24, Dr. Farrell did not adequately explain how appellant had a class 3, grade E impairment of 49 percent under Table 16-26. Her worksheet further indicates that she added the modifiers for functional history, physical examination, and clinical studies to the 49 percent to total left upper extremity impairment of 60 percent. This does not comport with section 15.5 which provides that, while Dr. Farrell may use her clinical judgment to decrease or increase the grade, she must explain in detail the rationale for any adjustments.[14] Table 15-26 provides that, prior to using the table, the examiner must review sections 15.1 and 15.5, and the diagnosis of CRPS must be defined by Table 15-24, and specified points threshold must be met as defined by Table 15-25.[15] Dr. Farrell did not state how she followed this analysis.

Dr. Harris agreed with Dr. Farrell that appellant had a 60 percent left upper extremity impairment due to CRPS without providing a rationalized explanation for his conclusion. He merely noted that appellant appeared to have continued problems with CRPS based on the reports of Dr. Farrell and Dr. Lampert. Dr. Harris disregarded Dr. Lampert's impairment analysis because the physician did not document findings consistent with CRPS.

Dr. Lampert based his left upper extremity rating on range of motion only. He found that under Table 15-32, Wrist Range of Motion, appellant had a 25 percent left upper extremity impairment. The sixth edition of the A.M.A., *Guides* provides that under certain circumstances, range of motion may be selected as an alternative approach in rating impairment.[16] Dr. Lampert selected this method of rating impairment because appellant did not fit into any table based on a diagnosis-based impairment. Table 15-32 provides that an ankylosed wrist with 30 degrees of

[12] Preexisting impairments to the scheduled member only are to be included in schedule award determinations. *See Peter C. Belkind*, 56 ECAB 580 (2005).

[13] A.M.A., *Guides*, *supra* note 2 at 453.

[14] *Id*. at 452.

[15] *Id*. at 454.

[16] *Id*. at 390. The A.M.A., *Guides* explains that diagnoses in the grid that may be rated using range of motion are followed by an asterisk.

flexion would be a 25 percent impairment.[17] If CRPS has not been accepted, Dr. Lampert's evaluation supports a 25 percent left upper extremity impairment. He also referenced a February 4, 2011 letter from OWCP asking for an addendum report. A copy of the February 4, 2011 letter is not in the case record.

Regarding the right upper extremity, again, Dr. Farrell's analysis does not comport with the A.M.A., *Guides*. She referenced Table 15-7 and Table 15-8.[18] As explained in section 15.3 of the A.M.A., *Guides*, these tables are to be used to calculate a net adjustment as provided in the net adjustment formula described above.[19] The additional right upper extremity conditions diagnosed by Dr. Farrell have not been accepted as employment related. Dr. Farrell's report is therefore insufficient to determine the extent of any right upper extremity impairment. Dr. Lampert and Dr. Harris both utilized Table 15-3, wrist regional grid, in rating appellant's right upper extremity. Dr. Lampert rated appellant at class 0 for no impairment whereas Dr. Harris rated appellant at class 1 for one percent impairment. Dr. Harris stated that his conclusion was based on residual problems. He noted that Dr. Farrell did not support her rating with sufficient documentation and Dr. Lampert found a normal range of motion. Dr. Harris did not explain the nature of the residual problems that formed the basis of his right upper extremity impairment rating. His report is insufficient to establish the extent of right upper extremity impairment.

Without a clear explanation of the accepted conditions and a detailed impairment evaluation that comports with the standards of the sixth edition of the A.M.A., *Guides*, the Board is unable to determine the degree of impairment to appellant's right or left upper extremities. The Board finds that the case must be remanded to OWCP for further development regarding the extent of appellant's impairment in accordance with the sixth edition of the A.M.A., *Guides.* After further development, to include an updated statement of accepted facts and such further development as deemed necessary, OWCP should issue an appropriate decision on appellant's impairment of her right and left arms.[20]

CONCLUSION

The Board finds this case is not in posture for decision.

[17] *Id*. at 473.

[18] *Id*. at 406, 408.

[19] *Id*. at 405-19.

[20] The Board notes that OWCP properly found that a schedule award is payable consecutively but not concurrently with an award for wage for the same injury. *See Jack D. Henwood*, Docket No. 95-596 (issued March 27, 1997) (where appellant asked that his schedule award be stopped, the Board found that OWCP properly interrupted payment of appellant's wage-loss benefits to pay his schedule award benefits).

ORDER

IT IS HEREBY ORDERED THAT the April 13, 2011 decision of the Office of Workers' Compensation Programs be vacated and the case remanded to OWCP for proceedings consistent with this opinion of the Board.

Issued: February 8, 2012
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board