United States Department of Labor
Employees' Compensation Appeals Board

C.C., Appellant	)	
and	)	**Docket No. 13-2082**
	)	**Issued: May 15, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Newtown, PA, Employer	)	

Appearances:
Thomas J. Uliase, 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 September 11, 2013 appellant, through her attorney, filed a timely appeal from a June 12, 2013 decision of the Office of Workers' Compensation Programs (OWCP) which affirmed a decision denying her claim for a schedule award. 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 case.

ISSUE

The issue is whether OWCP properly denied appellant's claim for a schedule award.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

This case has previously been before the Board.[2] In a May 17, 2000 decision, the Board set aside OWCP's denial of appellant's occupational disease claim and remanded the case for OWCP to refer her for a second opinion examination regarding whether her claimed right shoulder, arm and wrist conditions were caused by her employment.[3] In a June 12, 2007 decision, the Board affirmed OWCP decisions which denied her claim for a recurrence of disability.[4] The facts of the case are set forth in the Board's prior decision and are incorporated herein by reference.

On April 10, 2008 appellant filed a schedule award claim. She submitted an August 16, 2007 report from Dr. David Weiss, an osteopath, who provided an impairment rating under the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[5] (A.M.A., *Guides*). Dr. Weiss determined that appellant had reached maximum medical improvement and opined that she sustained 18 percent permanent impairment of the left upper extremity due to sensory deficits of the left C5 and C6 nerve roots and a left lateral pinch deficit. He found that she had 14 percent impairment of the right upper extremity due to sensory deficit in the right C5 nerve root and right lateral pinch deficit.

In an October 15, 2008 report, an OWCP medical adviser determined that appellant had eight percent impairment of the left arm and one percent impairment of the right arm under the fifth edition of the A.M.A., *Guides*. The medical adviser questioned the extent of objective findings made by Dr. Weiss, opined that the evidence did not substantiate the extent of the deficit on the left C5 and C6 nerve roots and advised that pinch deficit could not be used.

On December 28, 2009 OWCP referred appellant for a second opinion to Dr. Noubar A. Didizian, a Board-certified orthopedist, for an opinion on whether appellant had residuals of her accepted conditions and whether she had permanent impairment due to the accepted conditions. In a January 20, 2010 report, Dr. Didizian noted reviewing the June 15, 2000 statement of accepted facts (SOAF), history of injury and subsequent treatment. He noted that there were no objective orthopedic or neurologic deficit in the cervical spine or extremities found on clinical examination and therefore an impairment rating was inappropriate. Dr. Didizian found no objective evidence of residuals in the neck or upper extremities.

In a memorandum dated February 26, 2010, OWCP noted that the SOAF provided to Dr. Didizian was not updated and that a new SOAF should be prepared and forwarded to the second opinion physician for an addendum report.

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[2] On August 20, 1996 appellant, a postal clerk, filed a claim alleging that repetitive motion in sorting mail irritated and caused weakness in her right arm and shoulder. OWCP accepted brachial neuritis or radiculitis, mild ulnar neuropathy, hypermobility of the metacarpophalangeal joint and cervical radiculopathy.

[3] Docket No. 99-300 (issued May 17, 2000).

[4] Docket No. 07-483 (issued June 12, 2007).

[5] A.M.A., *Guides* (5th ed. 2001).

In a decision dated February 28, 2012, OWCP denied appellant's claim for a schedule award. Appellant requested an oral hearing.

In a decision dated May 11, 2012, an OWCP hearing representative set aside the February 28, 2012 decision and remanded the matter for further medical development. The hearing representative noted that Dr. Didizian, the second opinion physician, based his report on an incomplete SOAF which did not include a description of the accepted conditions. OWCP was instructed to prepare an updated SOAF and request an addendum report from Dr. Didizian.

OWCP prepared an updated SOAF dated June 1, 2012 which noted appellant's accepted claims as brachial neuritis or radiculitis, hypermobility of the metacarpophalangeal joint and cervical radiculopathy on September 26, 2001. The SOAF did not include mild ulnar neuropathy as an accepted condition.

Appellant submitted reports from Dr. Scott M. Fried, an osteopath, dated April 9 to June 13, 2012, who diagnosed metacarpophalangeal volar plate capsular injury with chronic laxity of the left thumb, disc space narrowing at C4-5, C5-6 with radiculopathy, right rotator cuff tendinitis and subacromial impingement, posterior occipital neuralgia right side, bilateral radial tunnel and left ulnar neuropathy, brachial plexopathy, cervical radiculopathy, thoracic neuritis and scapular winging, carpal tunnel neuropathy secondary to work activities.

On July 3, 2012 OWCP referred appellant to Dr. Didizian for a supplemental report regarding whether appellant had residuals of her accepted conditions and whether she had permanent impairment attributable to her accepted conditions. In a September 25, 2012 e-mail, OWCP noted that Dr. Didizian declined to provide another report.

In a September 26, 2012 letter, OWCP referred appellant to Dr. Robert F. Draper, Jr., a Board-certified orthopedist, for a determination of whether she has residuals of her accepted conditions and whether she had permanent impairment of the bilateral upper extremities. It provided Dr. Draper with the June 1, 2012 SOAF. In an October 5, 2012 report, Dr. Draper noted a history of appellant's work-related condition and reviewed the medical record. He noted examination findings of limited range of motion of the cervical spine, normal motor function for the deltoids, biceps, triceps, wrist extensors, wrist flexors, finger extensors, finger flexors, intact and symmetrical reflexes for the brachioradialis, biceps and triceps, normal light touch sensation test for the dermatome levels at C2 to C8 and T1. Dr. Draper noted normal range of motion of the elbow, forearm and wrists bilaterally, normal range of motion for the bilateral fingers for distal interphalangeal joints, proximal interphalangeal joint and metacarpophalangeal joint, no atrophy in the right hand, negative Tinel's sign over the median and ulnar nerve and no sensory deficit in the bilateral upper extremities. He noted the accepted diagnoses and advised that, on examination, he noted no evidence of hypermobility of the metacarpophalangeal joint and no evidence of aggravation of a preexisting condition. Dr. Draper noted symptoms of neuritis, radiculitis or cervical radiculopathy but advised that physical examination of motor and sensory function in the bilateral upper extremities was intact without evidence for these diagnoses. However, he stated that appellant had symptoms and the symptoms needed to be taken into account when determining an impairment rating. Dr. Draper opined that under the sixth edition

of the A.M.A., *Guides*[6] appellant had two percent impairment of the right and left arms. He noted using Table 15-18, page 429, Impairment for Sensory Following Peripheral Nerve Injury, for evaluating subjective complaints of paresthesias in the upper extremities in the absence of physical examination findings. Dr. Draper selected the mild category for retained protective sensation and pain, for two percent impairment of the left upper extremity and right upper extremity. He noted that the net adjustment formula yielded no adjustment.

In a December 15, 2012 report, an OWCP medical adviser found no basis for an upper extremity impairment in either arm. He noted that Dr. Draper found no objective evidence of hypermobility of the metacarpophalangeal joint or upper extremity sensory or motor deficits on clinical examination related to the accepted condition of cervical radiculopathy and brachial neuritis. With regard to the brachial neuritis, the medical adviser noted that an electromyogram did not indicate brachial nerve issues and there were no objective clinical findings of this condition. If there were findings, he noted that the appropriate table in the A.M.A., *Guides* would be Table 15-14, not Table 15-18 as used by Dr. Draper. The medical adviser noted that Table 15-14 required abnormalities on objective sensory and motor testing for a ratable impairment. With regard to cervical radiculopathy, he referenced *The Guides Newsletter* of July/August 2009 to rate the severity of objective sensory deficits. As Dr. Draper noted no abnormalities on objective sensory and motor deficits upon testing in either upper extremity the final impairment zero percent for the bilateral upper extremities. For hypermobility of the metacarpalphalangeal joint, the medical adviser noted that Dr. Draper found no hypermobility and therefore no basis for impairment for this condition. He noted the date of maximum improvement was October 5, 2012.

In a decision dated January 7, 2013, OWCP denied appellant's claim for a schedule award.

On January 11, 2013 appellant requested an oral hearing which was held on April 11, 2013. Appellant's attorney asserted that the SOAF was inaccurate as it did not list ulnar neuropathy as an accepted condition. Appellant submitted reports from Dr. Fried, dated May 1, 2012 to May 7, 2013, who diagnosed metacarpophalangeal volar plate capsular injury with chronic laxity of the left thumb, disc space narrowing at C4-5, C5-6 with radiculopathy, right rotator cuff tendinitis and subacromial impingement, posterior occipital neuralgia right side, bilateral radial tunnel and left ulnar neuropathy, brachial plexopathy, cervical radiculopathy, thoracic neuritis and scapular winging, carpal tunnel neuropathy secondary to work activities. She submitted an April 8, 2013 impairment rating from Dr. Weiss, who applied the updated edition of the A.M.A., *Guides* (6th ed. 2008) to his August 16, 2007 examination findings. Dr. Weiss found a combined 14 percent impairment of the left arm and 4 percent impairment of the right arm. For the left arm, he found one percent impairment for a mild sensory deficit of the left C5 nerve root, two percent impairment for mild sensory deficit of the left C6 nerve root, five percent impairment for entrapment neuropathy of the left ulnar nerve at the elbow, six percent impairment of the left arm for left thumb metacarpophalangeal subluxation. For the right arm, Dr. Weiss found one percent impairment for mild sensory deficit of the right C5 nerve root and three percent impairment for right shoulder acromioclavicular arthropathy.

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

In a June 12, 2013 decision, an OWCP hearing representative affirmed the decision dated January 7, 2013. The hearing representative found that the statement of accepted facts was accurate as the accepted condition of brachial neuritis or radiculitis encapsulated appellant's mild ulnar neuropathy.

LEGAL PRECEDENT

Section 8107 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. 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.[9] For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[10]

Although the A.M.A., *Guides* includes guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under FECA for injury to the spine.[11] In 1960, amendments to FECA modified the schedule award provisions 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. Therefore, as the schedule award provisions of FECA include 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.[12]

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as impairments of the extremities. Recognizing that FECA allows ratings for extremities and precludes ratings for the spine, *The Guides Newsletter* offers an approach to rating spinal nerve impairments consistent with sixth edition methodology.[13] OWCP has adopted this approach for rating impairment to the upper or lower extremities caused by a spinal injury.[14]

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] *Id.* at § 10.404(a).

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

[11] *Pamela J. Darling*, 49 ECAB 286 (1998).

[12] *Thomas J. Engelhart*, 50 ECAB 319 (1999).

[13] *L.J.*, Docket No. 10-1263 (issued March 3, 2011).

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

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 percentage of impairment using the A.M.A., *Guides*.[15]

OWCP's Procedure Manual provides as follows:

> "The [claims examiner] is responsible for ensuring that the SOAF is correct, complete, unequivocal, and specific. When the [district medical adviser], second opinion specialist or referee physician renders a medical opinion based on an SOAF which is incomplete or inaccurate or does not use the SOAF as the framework in forming his or her opinion, the probative value of the opinion is seriously diminished or negated altogether."[16]

ANALYSIS

Appellant's claim was accepted by OWCP for brachial neuritis or radiculitis, mild ulnar neuropathy, hypermobility of the metacarpophalangeal joint and cervical radiculopathy. On April 10, 2008 she claimed a schedule award and submitted an August 16, 2007 report from Dr. Weiss, who found 18 percent permanent impairment of the left arm and 14 percent impairment of the right arm under the fifth edition of the A.M.A., *Guides*. On October 15, 2008 an OWCP medical adviser differed with Dr. Weiss and opined that appellant had eight percent impairment of the left arm and one percent impairment of the right arm under the fifth edition of the A.M.A., *Guides*.

Thereafter, OWCP determined that further development was warranted and it subsequently referred appellant for a second opinion to Dr. Draper.[17] It requested that Dr. Draper review a June 1, 2012 SOAF and address whether appellant sustained impairment to the bilateral upper extremities causally related to the accepted employment injury. In the SOAF, however, OWCP failed to specify that it had accepted mild ulnar neuropathy. It provides a physician with a SOAF to assure that the medical specialist's report is based upon a proper factual background.[18] The SOAF must include the date of injury, claimant's age, the job held on the date of injury, the employer, the mechanism of injury and the claimed or accepted conditions.[19] OWCP procedures further indicate that, when an OWCP medical adviser, second

[15] *Tommy R. Martin*, 56 ECAB 273 (2005). *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

[16] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.3 (October 1990).

[17] The Board notes that, after OWCP initially referred appellant for a second opinion with Dr. Didizian, it requested a supplemental report from Dr. Didizian but was informed that he would not provide a supplemental report. OWCP acted properly in referring appellant for another opinion. *See Ayanle A. Hashi*, 56 ECAB 234 (2004) (when OWCP refers a claimant for a second opinion evaluation and the report does not adequately address the relevant issues, OWCP should secure an appropriate report on the relevant issues).

[18] *Helen Casillas*, 46 ECAB 1044 (1995).

[19] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Statements of Accepted Facts*, Chapter 2.809.5 (September 2009); *see also Darletha Coleman*, 55 ECAB 143 (2003).

opinion specialist or referee physician renders a medical opinion based on a SOAF which is incomplete or inaccurate or does not use the SOAF as the framework in forming his or her opinion, the probative value of the opinion is seriously diminished or negated altogether.[20] As Dr. Draper rendered his opinion based on incomplete factual information, it is of limited probative value. OWCP has the responsibility to obtain from its referral physician an evaluation that will resolve the issue involved in this case.[21] Accordingly, the Board finds that the case must be remanded for further medical development as Dr. Draper's opinion is of diminished probative value as it was based on an incomplete SOAF.

On remand OWCP should prepare a complete, accurate and updated SOAF and refer appellant to an appropriate medical specialist for examination and a reasoned opinion of whether she sustained permanent impairment of the bilateral upper extremities causally related to her accepted work injuries. Following such further development as deemed necessary, it shall issue a *de novo* decision.[22]

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that the case is not in posture for decision.

[20] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.3 (October 1990).

[21] *Richard F. Williams*, 55 ECAB 343 (2004).

[22] Counsel argued that Dr. Weiss' April 8, 2013 impairment rating under the A.M.A., *Guides* (6th ed. 2008) created a medical conflict. In his April 8, 2013 report, Dr. Weiss merely applied the latest version of the A.M.A., *Guides* to his August 16, 2007 examination findings. While Dr. Weiss' most recent report provided an impairment rating under the sixth edition of the A.M.A., *Guides*, his report is not based on current findings. Dr. Weiss' impairment rating contained in his April 8, 2013 report is thus of diminished probative value and insufficient to create a medical conflict. *See W.M.*, Docket No. 12-773 (issued March 29, 2013) (where the concurring opinion found that Dr. Weiss' dated, blended or composite reports offering opinions reached in 2010 based on a physical examination in 2006 are of diminished probative value); *J.K.*, Docket No. 11-1765 (issued April 12, 2012) (where the Board found that a physician's report in 2011 was of diminished probative value upon which to base a current permanent impairment rating as his findings were based on an examination performed in 2006); *C.W.*, Docket No. 12-1211 (issued November 15, 2012) (the Board found that applying the latest version of the A.M.A., *Guides* to 2007 examination findings did not create a conflict with a referee physician's opinion which was based on considerably more recent examination findings).

ORDER

IT IS HEREBY ORDERED THAT the June 12, 2013 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision by the Board.

Issued: May 15, 2014
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