United States Department of Labor
Employees' Compensation Appeals Board

B.G., Appellant	)	
and	)	**Docket No. 14-1582**
	)	**Issued: November 6, 2014**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Dublin, GA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 8, 2014 appellant filed a timely appeal from an April 25, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP) which denied 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 this case.

ISSUE

The issue is whether appellant has a ratable impairment of the upper extremities.

FACTUAL HISTORY

Appellant, a 64-year-old former lead file clerk, has an accepted occupational disease claim for bilateral carpal tunnel syndrome (CTS), which arose on or about February 21, 2012.[2]

[1] 5 U.S.C. §§ 8101-8193.

[2] Appellant has also been diagnosed with peripheral neuropathy and osteoarthritis of the hands, which OWCP has not accepted as employment related.

She retired effective June 30, 2012. Appellant underwent a right carpal tunnel release on July 9, 2012, followed by a left carpal tunnel release on October 15, 2012. Dr. James D. Peters, a Board-certified orthopedic surgeon, performed both procedures, which OWCP authorized.

On July 10, 2013 appellant filed a claim (Form CA-7) for a schedule award. Dr. Peters provided a March 2, 2013 impairment rating that referenced the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (2001). He diagnosed bilateral carpal tunnel syndrome and noted that appellant had undergone carpal tunnel releases on July 9 and October 15, 2012. Dr. Peters found three percent whole person impairment. He indicated that the rating was based on impairment of the left hand secondary to residual dysesthetic pain into the index finger.

In a report dated July 12, 2013, Dr. Howard "H.P." Hogshead, a Board-certified orthopedic surgeon and district medical adviser, found one percent bilateral upper extremity impairment based on residual dysesthesias. He diagnosed bilateral CTS and rated appellant under Table 15-23, Entrapment/Compression Neuropathy Impairment, A.M.A., *Guides* 449 (6th ed. 2008). Dr. Hogshead opined that Dr. Peters' March 2, 2013 impairment rating was incorrect.

OWCP forwarded a copy of Dr. Hogshead's July 12, 2013 report to Dr. Peters for his review. On July 31, 2013 Dr. Peters noted his disagreement, but did not otherwise explain why he disagreed with Dr. Hogshead's assessment.

OWCP declared a conflict in medical opinion and referred appellant for an impartial medical evaluation.

Dr. Jeffrey C. Easom, a Board-certified orthopedic surgeon and impartial medical examiner, saw appellant on October 22, 2013. As part of his examination, he administered an upper extremity nerve conduction study (NCS), which was interpreted as normal and negative for bilateral CTS.[3] Although the latest electrodiagnostic study was normal/negative, appellant's

[3] The October 22, 2013 study did not include bilateral upper extremity needle electromyography.

symptoms were noted to be consistent with carpal tunnel syndrome. Dr. Easom diagnosed bilateral CTS and found two percent bilateral upper extremity impairment under Table 15-23, A.M.A., *Guides* 449 (6th ed. 2008).[4]

In a report dated November 26, 2013, a new district medical adviser, Dr. Guillermo M. Pujadas, a Board-certified orthopedic surgeon, questioned Dr. Easom's October 22, 2013 impairment rating based on entrapment neuropathy. He explained that an impairment rating under Table 15-23, A.M.A., *Guides* 449 (6th ed. 2008) must be premised on positive preoperative electrodiagnostic evidence of CTS. Dr. Pujadas noted that appellant's February 2012 preoperative NCS did not meet the criteria for rating impairment under Table 15-23.[5] He recommended that OWCP obtain clarification from Dr. Easom regarding his interpretation of appellant's electrodiagnostic studies.

In a March 18, 2014 supplemental report, Dr. Easom noted that appellant's preoperative electrodiagnostic study revealed normal nerve conduction. He reiterated his prior diagnosis of bilateral CTS. Because of appellant's normal electrodiagnostic study, which were not available at the time of the initial evaluation, Dr. Easom found zero percent upper extremity impairment under Table 15-23, A.M.A., *Guides* 449 (6th ed. 2008).

On April 24, 2014 another district medical adviser, Dr. James W. Dyer, a Board-certified orthopedic surgeon, reviewed the case file and commented that Dr. Easom's October 22, 2013 report was thorough, detailed and reflected the correct use of the A.M.A., *Guides* (6th ed. 2008). According to him, the October 22, 2013 report provided an "accurate [schedule award] for both [upper extremities] due to [bilateral] CTS." Dr. Dyer did not specifically mention Dr. Easom's March 18, 2014 supplemental report.

By decision dated April 25, 2014, OWCP denied appellant's claim for a schedule award. According to OWCP, the "DMA stated that the corrected report by Dr. Easom dated [March 18, 2014] is a thorough detailed report that reflects the correct use of the [AMA, *Guides*]...."

LEGAL PRECEDENT

Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[6] FECA, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The

[4] Dr. Easom assigned a grade modifier of 1 for test findings and a grade modifier of 2 for both history and physical findings. Additionally, he assigned a grade modifier of 1 for functional scale based on a reported *Quick*DASH score of 25. Dr. Easom then added the four above-noted grade modifiers (1+2+2+1=6) and divided by 4, resulting in an average grade modifier of 1.5, which he then rounded down to grade 1. Under Table 15-23, A.M.A., *Guides* 449 (6th ed. 2008), the default upper extremity rating for a grade 1 impairment is two percent. As discussed *infra*, Dr. Easom's October 22, 2013 impairment rating is deficient for several reasons.

[5] The previous DMA, Dr. Hogshead, noted in his July 12, 2013 report that appellant's February 29, 2012 electrodiagnostic study was completely normal. Based on the current record, the February 2012 study appears to have been the last upper extremity NCS administered prior to appellant's July 9 and October 15, 2012 surgeries.

[6] For total loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1).

implementing regulations have adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[7] Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2008).[8]

When determining entitlement to a schedule award, preexisting impairment to the scheduled member should be included.[9] Impairment ratings for schedule awards include those conditions accepted by OWCP as job related and any preexisting permanent impairment of the same member or function.[10] If the work-related injury has affected any residual usefulness in whole or in part, a schedule award may be appropriate.[11] There are no provisions for apportionment under FECA.[12] When the prior impairment is due to a previous work-related injury and a schedule award has been granted for such prior impairment, the percentage already paid is subtracted from the total percentage of impairment.[13]

If there is disagreement between the physician making the examination for OWCP and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[14] For a conflict to arise the opposing physicians' viewpoints must be of "virtually equal weight and rationale."[15] Where OWCP has referred the employee to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[16]

ANALYSIS

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

OWCP declared a conflict in medical opinion based on differing impairment ratings between Dr. Peters, appellant's physician, and Dr. Hogshead, one of several district medical adviser's involved in the case. For a conflict to arise the opposing physicians' viewpoints must

[7] 20 C.F.R. § 10.404.

[8] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *id*. at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6a (February 2013).

[9] *Carol A. Smart*, 57 ECAB 340, 343 (2006); *Michael C. Milner*, 53 ECAB 446, 450 (2002).

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5d (February 2013).

[11] *Id.*

[12] *Id.*

[13] *Id.* at Chapter 2.808.7a(1); 20 C.F.R. § 10.404(c).

[14] 5 U.S.C. § 8123(a); *see* 20 C.F.R. § 10.321; *Shirley L. Steib*, 46 ECAB 309, 317 (1994). The district medical adviser acting on behalf of OWCP may create a conflict in medical opinion. 20 C.F.R. § 10.321(b).

[15] *Darlene R. Kennedy*, 57 ECAB 414, 416 (2006).

[16] *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

be of "virtually equal weight and rationale."[17] In his March 2, 2013 report, Dr. Peters applied an outdated version of the A.M.A., *Guides* and offered no explanation for his three percent whole person impairment rating.[18] Dr. Hogshead on the other hand applied the latest edition of the A.M.A., *Guides* (6th ed. 2008). He criticized Dr. Peters for not explaining his impairment rating, but the district medical adviser similarly failed to provide an explanation for his July 12, 2013 rating under Table 15-23, A.M.A., *Guides* 449 (6th ed. 2008). Also, Dr. Hogshead specifically noted that appellant's February 29, 2012 electrodiagnostic studies were "completely normal," which, as discussed *infra*, precludes a rating under Table 15-23. On July 31, 2013 Dr. Peters noted his disagreement with Dr. Hogshead's rating, but again offered no explanation. Thus, neither him nor Dr. Hogshead provided a rationalized opinion regarding the nature and extent of any upper extremity impairment under the A.M.A., *Guides* (6th ed. 2008). Absent a true conflict in medical opinion, Dr. Easom's October 22, 2013 OWCP-directed examination is relegated to second opinion status.

Dr. Easom initially found two percent bilateral upper extremity impairment under Table 15-23, A.M.A., *Guides* 449 (6th ed. 2008). However, his October 22, 2013 rating was deficient for several reasons. First, Dr. Easom calculated an average grade modifier of 1.5, which he then rounded-down to grade 1.[19] Assuming the 1.5 calculation was correct, he should have rounded up to grade 2 impairment rather than down to grade 1.[20] Dr. Easom also erred by including functional scale when determining the average grade modifier.[21] The functional scale grade modifier is taken into account only after the average graded modifier is determined based on test findings, history and physical findings.[22] Lastly, Dr. Easom's October 22, 2013 rating under Table 15-23 was incorrect because appellant's preoperative electrodiagnostic study was normal.[23] In cases where surgical decompression has been performed and the preoperative study fails to meet the specified criteria -- abnormal result(s), then Table 15-23 cannot be used to rate upper extremity impairment.[24] On March 18, 2014 Dr. Easom amended his October 22, 2013 rating to reflect zero percent bilateral upper extremity impairment because of appellant's normal preoperative electrodiagnostic study, but where Table 15-23 is inapplicable, such cases may still be rated under Section 15.2, Diagnosis-Based Impairment, using the appropriate class for nonspecific hand/wrist pain.[25]

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[17] *Supra* note 15.

[18] Neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back/spine or the body as a whole. 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404; *see Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

[19] *See supra* note 4.

[20] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3b (June 2003).

[21] *See* A.M.A., *Guides* 448-49 (6th ed. 2008).

[22] *Id.* The Board notes that Dr. Hogshead's July 12, 2013 impairment rating was similarly flawed.

[23] *See* Section 15.4f, Entrapment Neuropathy, A.M.A., *Guides* 445-46, 448-49 (6th ed. 2008). "Test findings are the 'key factor' for determining impairment in this section." *Id.* at 446.

[24] *Id.* at 449.

[25] *Id.* at 446.

Once OWCP undertakes development of the record it must do a complete job in procuring medical evidence that resolves the relevant issues in the case.[26] The question of whether appellant has any upper extremity impairment remains unresolved. While it is evident she has no ratable impairment under Table 15-23, A.M.A., *Guides* 449 (6th ed. 2008), in this instance neither Dr. Easom nor the district medical adviser addressed alternative methods of determining the extent of appellant's upper extremity impairment. Consequently, OWCP's April 25, 2014 decision shall be set aside and the case remanded for further medical development. After OWCP has developed the record to the extent it deems necessary, a *de novo* decision shall be issued.

CONCLUSION

The case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the April 25, 2014 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this decision.

Issued: November 6, 2014
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

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

[26] *Richard F. Williams*, 55 ECAB 343, 346 (2004).