United States Department of Labor
Employees' Compensation Appeals Board

C.H., Appellant	)	
and	)	**Docket No. 15-109**
	)	**Issued: April 16, 2015**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Lexington, KY, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 20, 2014 appellant timely appealed the August 1, 2014 merit 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 this case.

ISSUE

The issue is whether appellant is entitled to an additional schedule award for impairment of the right (arm/shoulder) upper extremity.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

This case was previously before the Board.[2] Appellant, a 43-year-old former nursing assistant, has an accepted claim for right hand sprain and right arm chronic regional pain syndrome (CRPS), which arose on April 17, 2009.[3] She was injured when a combative patient kicked and slammed her hand into a bedrail. Appellant also sustained an employment-related right hand/thumb injury on December 17, 2009, which OWCP accepted for right metacarpophalangeal sprain (file number xxxxxx630). In December 2010, she underwent OWCP-authorized surgery to implant a spinal cord stimulator.

On September 27, 2011 appellant received a schedule award for 20 percent impairment of the right hand. The award covered a period of 48.8 weeks beginning April 8, 2011. When the case was last on appeal, the Board modified the September 27, 2011 schedule award to reflect 20 percent impairment of the right arm, instead of an impairment of the hand.[4] Accordingly, appellant was entitled to 62.4 weeks of compensation rather than 48.8 weeks as previously awarded.[5] On September 11, 2012 OWCP issued an amended schedule award finding 20 percent impairment of the right shoulder. Appellant received an additional 13.6 weeks of compensation through June 18, 2012.

On December 7, 2012 appellant filed a claim (Form CA-7) for an additional schedule award.

In an October 30, 2012 report, Dr. Donald R. Douglas noted that appellant currently complained of pain in the right elbow. Appellant described a burning sensation from her hand to her elbow, with sharp and stabbing pain mostly in the right elbow. Dr. Douglas indicated that he reviewed all of Chapter 15, "The Upper Extremities," A.M.A., *Guides* (6th ed. 2008), and currently found nothing that would meet the criteria of a CRPS.[6] However, he found upper extremity impairment related to decreased sensation from C6 through C8. Dr. Douglas noted that the loss of sensation was in varying degrees. He also noted appellant's motor tone was surprisingly intact, and her grip strength had improved in comparison to his July 27, 2011 examination. Also, there was no evidence of atrophy. In conclusion, Dr. Douglas indicated that appellant continued to show some decreased light touch in the C6 through C8 region.

[2] Docket No. 12-665 (issued August 1, 2012).

[3] The employing establishment removed appellant for cause effective November 1, 2011.

[4] The medical evidence upon which OWCP relied found 20 percent right upper extremity impairment based on a diagnosis of CRPS under Table 15-26, American Medical Association, *Guides to the Evaluation of Permanent Impairment* 454 (6th ed. 2008).

[5] The Board's August 1, 2012 decision is incorporated herein by reference (*supra* note 2).

[6] Dr. Douglas is an anesthesiologist specializing in pain medicine. The September 27, 2011 schedule award was based in part on his July 27, 2011 examination findings.

Dr. James W. Dyer, the district medical adviser (DMA), reviewed the record on December 17, 2012, and found that Dr. Douglas' October 30, 2012 findings did not support an additional schedule award above 20 percent impairment of the right upper extremity.[7]

On December 19, 2013 OWCP advised appellant that Dr. Douglas did not provide an impairment rating in his October 30, 2012 report; however, he provided an extensive assessment of her current medical condition, which Dr. Dyer determined did not support an increased schedule award. It provided her a copy of Dr. Dyer's December 17, 2012 report and suggested that she take the report to Dr. Douglas for his review. Appellant was afforded at least 30 days to submit additional medical evidence demonstrating a greater impairment under the A.M.A., *Guides* (6th ed. 2008).

By decision dated January 23, 2013, OWCP denied appellant's claim for an additional schedule award.

On November 15, 2013 appellant requested reconsideration. She submitted follow-up treatment notes from Dr. Douglas dated January 10, 2013. Dr. Douglas indicated that under the A.M.A., *Guides* (6th ed. 2008) appellant currently had four percent impairment.

In a December 19, 2013 decision, OWCP reviewed the merits of the claim, but denied modification of its January 23, 2013 decision. Whereas appellant interpreted Dr. Douglas' January 10, 2013 finding as entitling her to an additional 4 percent impairment, OWCP explained that he found that she currently had only 4 percent impairment of the right upper extremity, which was less than the previous 20 percent award. It further noted that Dr. Douglas had not explained how he arrived at his four percent rating.

On June 2, 2014 appellant requested reconsideration.

OWCP received February 17, 2012 and March 20, 2014 electrodiagnostic nerve conduction velocity (NCV)/electromyogram (EMG) studies that were both normal.

OWCP also received a report from Dr. Jessica M. Fairchild, a Board-certified internist, who examined appellant on February 24, 2014. Dr. Fairchild noted that appellant was seen in regard to a work-related injury from April 2009 when she dislocated her right thumb and sprained several ligaments in the area. She further noted that appellant inadvertently reinjured her right hand/thumb in December 2009, and ultimately received a diagnosis of regional pain syndrome or reflex sympathetic dystrophy (RSD) involving the right hand and wrist area. For this particular diagnosis, appellant continued to receive pain management therapy that included prescribed daily use of Lyrica and Lortab. She currently complained of electrical-type pain that increased in severity and began radiating upward toward the right elbow and shoulder, as well as her upper back. Appellant also experienced a similar pain sensation in her left elbow. Her pain was noted to be present regardless of her activity level. There was no appreciated localized joint swelling affecting the shoulders or elbows. Dr. Fairchild also noted there was no recent reinjury. Appellant denied any associated neck pain and there was no known history of cervical degenerative disc disease. A nerve conduction study in 2012 was reported to be within normal

[7] Dr. Dyer is a Board-certified orthopedic surgeon.

limits. Appellant did not recall the last time she had her neck x-rayed. Dr. Fairchild further noted there was no known history of inflammatory arthritis, such as gout or polymyalgia rheumatica.

On physical examination, Dr. Fairchild noted that appellant was in no apparent distress. Appellant's cervical spine was nontender and her paraspinal musculature was without obvious spasm. Additionally, her bilateral upper trapezia were without spasm or obvious abnormalities, and there was full range of motion in both shoulders. Dr. Fairchild also found no effusion and there was no tenderness over bony landmarks. Both elbows were without effusion or point tenderness, and appellant's epicondyles were also nontender. Appellant's bilateral wrists exhibited normal range of motion and no objective sensory deficits were present. Lastly, Dr. Fairchild noted that appellant's deep tendon reflexes were +2/+4 even and throughout.

Dr. Fairchild diagnosed right hand and wrist regional pain syndrome/RSD. She also diagnosed neuropathic pain affecting the right upper extremity, as well as appellant's shoulder, and left upper extremity pain. Dr. Fairchild referred appellant for x-rays of the cervical spine and a repeat NCV/EMG.[8]

In a March 20, 2014 report, Dr. Eric T. Morse, a Board-certified physiatrist, noted a history of CRPS and a prior work injury on April 17, 2009. Appellant's current complaints included sharp shooting pains, constant pain in right hand, arm, and shoulder. Dr. Morse diagnosed right hand CRPS. He provided work restrictions, but did not specifically address the extent of any right upper extremity impairment.

Dr. Fairchild subsequently referred appellant for a functional capacity evaluation (FCE). The May 14, 2014 FCE was prepared by Ryan Foister, a certified hand therapist and occupational therapist. With respect to right upper extremity impairment, Mr. Foister found six percent impairment of the thumb due to loss of range of motion and sensation. The noted right thumb impairment reportedly represented two percent impairment of the hand. Mr. Foister found an additional two percent impairment due to loss of motion in the wrist. Appellant's right wrist and thumb impairments represented four percent impairment of the upper extremity. Mr. Foister indicated his impairment rating was based on the fifth edition of the A.M.A., *Guides* (2001). However, he did not identify specific tables and/or figures he presumably relied upon.

In a report dated July 30, 2014, Dr. Howard "H.P." Hogshead, a Board-certified orthopedic surgeon and the DMA, found that Mr. Foister's May 14, 2014 impairment rating was not relevant to appellant's basic problem of CRPS. He further noted that recent studies and medical opinions did not alter his earlier opinion and OWCP's September 11, 2012 decision.[9] Consequently, Dr. Hogshead found zero percent additional impairment.

By decision dated August 1, 2014, OWCP found the new evidence insufficient to warrant modification of the December 19, 2013 decision. Appellant had not established entitlement to a schedule award in excess of 20 percent of the right upper extremity.

[8] Appellant's February 24, 2014 cervical x-rays revealed multilevel degenerative disease with no acute process.

[9] Dr. Hogshead's September 19, 2011 report formed the basis of the prior schedule award. *See supra* note 4.

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.[10] 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 implementing regulations have adopted the American Medical Association, *Guides to the Evaluation of Permanent Impairment* as the appropriate standard for evaluating schedule losses.[11] Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2008).[12]

FECA and its implementing regulations provide for the reduction of compensation for subsequent injury to the same schedule member.[13] Benefits payable under 5 U.S.C. § 8107(c) shall be reduced by the period of compensation paid under the schedule for an earlier injury if: (1) compensation in both cases is for impairment of the same member or function or different parts of the same member or function; and (2) the latter impairment in whole or in part would duplicate the compensation payable for the preexisting impairment.[14]

If a claimant sustains increased impairment at a later date which is due to work-related factors, an additional award will be payable if supported by the medical evidence.[15] In this case, the original award is undisturbed and the new award has its own date of maximum medical improvement, percent of impairment, and period of award.[16] This may occur if the claimant sustains additional impairment due to the original work factors with no intervening or additional exposure to those same work factors.[17]

ANALYSIS

OWCP previously awarded appellant 20 percent impairment of the right (arm/shoulder) upper extremity. The award was based on a diagnosis of CRPS under Table 15-26, A.M.A.,

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

[11] 20 C.F.R. § 10.404.

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

[13] 5 U.S.C. § 8108; 20 C.F.R. § 10.404(c).

[14] 20 C.F.R. § 10.404(c)(1), (c)(2).

[15] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.9b (February 2013).

[16] *Id.*

[17] *Id.*

Guides 454 (6th ed. 2008). Appellant later requested an additional schedule award. In his October 30, 2012 report, Dr. Douglas noted there were no findings that would currently satisfy the criteria for CRPS. However, he found upper extremity impairment related to decreased sensation from C6 through C8. Unfortunately, Dr. Douglas failed to quantify the extent of appellant's right upper extremity sensory deficit. Dr. Dyer, the DMA, reviewed Dr. Douglas' October 30, 2012 findings and found the evidence did not support an additional schedule award above 20 percent impairment of the right upper extremity. OWCP afforded appellant the opportunity to respond to Dr. Dyer's opinion, but she did not timely reply. Consequently, it properly denied her claim for an additional schedule award.

Appellant subsequently requested reconsideration and submitted Dr. Douglas' January 10, 2013 finding of four percent impairment. Although Dr. Douglas indicated that the rating was pursuant to the A.M.A., *Guides* (6th ed. 2008), he did not identify any applicable tables and/or figures, and he otherwise failed to explain how he arrived at his finding of four percent impairment. Appellant failed to establish that she has greater than 20 percent impairment of the right upper extremity. Therefore, OWCP properly denied modification of its January 23, 2013 decision.

Appellant's latest request for reconsideration was accompanied by recent upper extremity electrodiagnostic studies that were interpreted as normal. She also submitted two recent reports from Dr. Fairchild and Dr. Morse. While both physicians diagnosed right hand/wrist CRPS, neither one provided an upper extremity impairment rating in accordance with the A.M.A., *Guides* (6th ed. 2008).[18] Moreover, Dr. Hogshead, the DMA, reviewed the latest objective studies and medical opinions and found that the latest evidence did not alter his earlier opinion regarding the extent of appellant's right upper extremity impairment.

Appellant also submitted a May 14, 2014 FCE prepared by a hand/occupational therapist. Mr. Foister found four percent impairment of the right upper extremity under the A.M.A., *Guides* (5th ed. 2001). First, he is not a "physician" as defined under FECA.[19] Therefore, Mr. Foister's May 14, 2014 opinion will not suffice for purposes of establishing entitlement to FECA benefits.[20]

The Board finds that OWCP properly denied appellant's claim for an additional schedule award. Appellant had already received an award for 20 percent impairment of the right (arm/shoulder) upper extremity, and subsequent medical evidence failed to establish greater upper extremity impairment than previously awarded.

[18] *See* Table 15-24, Table 15-25, and Table 15-26, A.M.A., *Guides* 453-54 (6th ed. 2008).

[19] Certain healthcare providers such as physician assistants, nurse practitioners, physical therapists, and social workers are not considered "physician[s]" as defined under FECA. 5 U.S.C. § 8101(2); 20 C.F.R. § 10.5(t).

[20] *K.W.*, 59 ECAB 271, 279 (2007); *David P. Sawchuk*, 57 ECAB 316, 320 n.11 (2006). A report from a physician assistant or certified nurse practitioner will be considered medical evidence if countersigned by a qualified physician. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3a(1) (January 2013).

CONCLUSION

Appellant failed to establish entitlement to an additional schedule award for impairment of the right (arm/shoulder) upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the August 1, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 16, 2015
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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