United States Department of Labor
Employees' Compensation Appeals Board

P.D., Appellant	)	
and	)	**Docket No. 15-1111**
	)	**Issued: December 7, 2015**
DEPARTMENT OF JUSTICE, BUREAU OF PRISONS, FEDERAL CORRECTIONS COMPLEX CARSWELL, Fort Worth, TX, Employer	)	

Appearances:
Edward L. Daniel, for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On April 20, 2015 appellant, through her representative, filed a timely appeal from a March 10, 2015 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 has established that she sustained more than five percent impairment to her left upper extremity and more than five percent to her right upper extremity, for which she has received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On December 4, 2009 appellant, then a 44-year-old food service supervisor, filed an occupational disease claim (Form CA-2) alleging that she sustained upper extremity conditions due to factors of her federal employment. OWCP initially accepted the claim for right carpal tunnel syndrome and right median nerve lesions. It subsequently amended the accepted conditions to include bilateral carpal tunnel syndrome; bilateral median nerve lesions, bilateral enthesopathy of the wrist and carpus; bilateral trigger finger (acquired); sprain of neck; brachial neuritis or radiculitis; bilateral injury to median nerve; bilateral localized primary osteoarthritis, forearm; bilateral calcifying tendinitis of shoulder; bilateral localized primary osteoarthritis, shoulder region; bilateral sprain of shoulder and upper arm, superior glenoid, labrum lesion; bilateral medial epicondylitis; and bilateral olecranon bursitis. The record does not indicate that appellant stopped work.

Under OWCP file number xxxxxx195, date of injury May 4, 2009, OWCP accepted the conditions of closed fracture of right phalange and right carpal tunnel syndrome when appellant slammed a door on her right index finger. This claim was administratively combined with the current claim.

On April 26, 2013 appellant filed a claim for a schedule award. In a January 8, 2013 report, Dr. John W. Ellis, a family practitioner, noted the history of her work injuries and his review of the medical records. He set forth findings on examination and diagnosed the following conditions: For diagnoses due to OWCP file number xxxxxx195, Dr. Ellis found fracture of right index finger distal interphalangeal (DIP) joint, right carpal tunnel syndrome, and organic depression. For diagnoses due to OWCP file number xxxxxx335, he found: bilateral wrist tendinitis with carpal tunnel syndrome, bilateral triggering of the thumbs, bilateral medial epicondylitis, bilateral olecranon bursitis, bilateral cubital tunnel syndrome, bilateral radial tunnel syndrome, bilateral traumatic arthritis, tendinitis and osteoarthritis of the shoulders, bilateral reflex spasm of the neck and shoulder girdles causing bilateral brachial plexus impingement and neuritis. Dr. Ellis opined that all diagnoses were aggravated and/or caused by appellant's employment factors and work duties and provided medical rationale for his opinion. He opined maximum medical improvement was reached January 8, 2013 and that she remained temporarily totally disabled as a result of her different surgeries. Dr. Ellis noted that appellant had undergone a right carpal tunnel release on March 23, 2010, left carpal tunnel release on September 21, 2010, right thumb release of stenosing tenosynovitis and synovectomy of the flexor pollicis longus on January 5, 2011, and a second right carpal tunnel surgery with decompression of the median nerve on June 28, 2011.

Under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[2] (hereinafter A.M.A., *Guides*), Dr. Ellis opined that under master file number xxxxxx335, appellant had the following impairments: For the right upper extremity, diagnosis-based impairments were 20 percent and peripheral nerve impairments were 15 percent, for a total combined impairment of 32 percent. For the left upper extremity, diagnosis based impairments were 15 percent and peripheral nerve impairments were 15 percent, for a total

[2] A.M.A., *Guides* (6th ed. 2009).

combined impairment of 28 percent. Impairment worksheets which set forth the examination findings and the methodologies used to compute the impairment ratings were provided.

In a July 3, 2013 report, an OWCP medical adviser under OWCP file number xxxxxx195, reviewed a statement of accepted facts and Dr. Ellis' impairment evaluation for a schedule award of the upper extremities. He noted that several electromyogram (EMG) and nerve conduction velocity (NCV) reports showed variable interpretations as to the presence of carpal tunnel syndrome, but none demonstrated ulnar nerve entrapment or revealed a motor block. The medical adviser noted that Dr. Ellis' report was of concern for several reasons, including his characterization of index finger impairment as an upper extremity impairment, the inclusion of diagnoses that were not validated by the record, multiple diagnoses not included in the accepted conditions, and questionable classification of the EMG/NCV studies. Because of those concerns, he recommended that OWCP obtain an impairment evaluation from Board-certified physician familiar with the sixth edition of the A.M.A., *Guides* and OWCP procedures.

On July 19, 2013 appellant filed another Form CA-7 requesting a schedule award.

In a September 3, 2013 report, Dr. James E. Butler, a Board-certified orthopedic surgeon and OWCP referral physician, noted the history of the work injuries, reviewed the statement of accepted facts and appellant's medical record, and set forth findings examination. He diagnosed cervical degenerative disc disease with C6 radiculopathy by EMG, clinically normal; bilateral shoulder sprain/strain resolved, bilateral medial epicondylitis, resolved, bilateral carpal tunnel syndrome, operated, stable; right thumb trigger finger, operated, resolved; and depression disorder. Dr. Butler opined that appellant reached maximum medical improvement on January 8, 2013. He found no limitation in range of motion of the right index finger, right thumb, right elbow, right wrist, right shoulder, left elbow, left wrist and left shoulder and provided range of motion values. Dr. Butler further noted that on examination strength testing was essentially normal and no atrophy seen. There was some mild tenderness noted on bilateral wrists and hands. Shoulders and elbows were nontender. There was some mildly decreased sensation reported in the bilateral median nerves with no ankyloses. Under the sixth edition of the A.M.A., *Guides*, Dr. Butler opined that appellant had a total of five percent right upper extremity impairment and a total of five percent left upper extremity impairment.

For the right upper extremity, the following calculations were provided: For right thumb trigger finger, under Table 15-2, page 392, this was class 0 with no residual findings. Thus, zero percent impairment was assigned for the right thumb injury. For right carpal tunnel syndrome, under Table 15-23, page 449, clinical study findings were grade 1, history findings were grade 2 with significant intermittent symptoms, and physical findings were grade 2 with mildly decreased sensation. The grade modifier total was 5 and averaged 1.66. Therefore, the grade 2 was selected. The *Quick*DASH score was 48, so the functional scale was moderate with no modification needed. Thus, appellant was found to have five percent right upper extremity impairment. For right elbow medial epicondylitis, under Table 15-4, page 399, class 0 was selected as there were no significant objective abnormal findings. Thus, Dr. Butler found zero percent impairment was assigned for right upper extremity impairment of the right elbow injury. For right shoulder sprain/strain, a class 0 was given based on Table 15-5, page 401 as there were no significant objective abnormal findings of muscle or tendon injury. Thus, zero percent impairment was assigned for the right shoulder injury. Under the Combined Values Chart,

Dr. Butler combined five percent (right wrist) with zero percent (right thumb, right elbow, and right shoulder) and found appellant had a total five percent right upper extremity impairment rating.

For the left upper extremity, the following calculations were provided: For left carpal tunnel syndrome: under Table 15-23, page 449, grade 1 was provided for clinical study findings; grade 2 was provided for history findings with significant intermittent symptoms; and grade 2 physical findings were provided for mildly decreased sensation. The grade modifier total was 5, with an average of 1.66. Therefore, grade 2 was selected. The *Quick*DASH score was 48, so the functional scale was moderate with no modifications needed. Therefore, appellant was assigned five percent left upper extremity impairment. For the left elbow medial epicondylitis, under Table 15-4, page 399, class 0 was provided as there was no significant objective abnormal findings. Thus, zero percent impairment provided for left elbow injury. For left shoulder sprain/strain, under Table 15-5, page 401, class 0 was provided as there were no significant objective abnormal finding of muscle or tendon injury. Thus, zero percent impairment was assigned for the left shoulder injury. Under the Combined Values Chart, combining five percent (left wrist) with zero percent (left elbow and left shoulder), resulted in a five percent total left upper extremity impairment rating.

On October 18, 2013 an OWCP medical adviser reviewed the case record in order to assess the date of maximum medical improvement, functional loss of use, and percentage of impairment under the sixth edition of the A.M.A., *Guides.* He noted that on January 8, 2013 Dr. Ellis submitted an impairment evaluation for 32 percent right upper extremity and 28 percent left upper extremity impairment under various conditions. The medical adviser noted that, under file number xxxxxx195, another medical advisor had reviewed Dr. Ellis' report on July 3, 2013 and found it was not probative and had recommended a second opinion impairment evaluation, which Dr. Butler had performed on September 3, 2013. Using Dr. Butler's clinical assessments under the A.M.A., *Guides*, he opined that the date of maximum medical improvement was January 8, 2013 for both upper extremities and concurred with Dr. Butler's findings of five percent right upper extremity impairment and five percent left upper extremity impairment as proper under the A.M.A., *Guides*.

By decision dated March 4, 2014, OWCP granted appellant a schedule award for five percent right upper extremity impairment and five percent left upper extremity impairment. The award ran for 31.2 weeks of compensation for the period January 8 to August 14, 2013.

On July 30, 2014 OWCP received appellant's representative's request for reconsideration. In his July 25, 2014 letter, the representative noted the concerns of the medical adviser who reviewed Dr. Ellis' January 8, 2013 examination[3] and that appellant was directed to a second opinion examination a result of those concerns. He noted that based on Dr. Butler's second opinion assessment and the second medical adviser's agreement with Dr. Butler's assessment, a schedule award was issued. The representative contended that a conflict of medical opinion existed between Dr. Ellis and the first OWCP medical adviser, requiring a

[3] Appellant's representative noted that the original medical advisers had concerns over Dr. Ellis' characterization of the index finger impairment as upper extremity impairment, inclusion of multiple diagnoses that were not included in the accepted conditions, and questionable classification of the EMG/NCV studies.

referral for an impartial medical examination. He also submitted a new report from Dr. Ellis dated June 5, 2014. The representative requested that a medical adviser review the new report and, if the medical adviser disagreed with the report, then appellant should be referred for an impartial medical examination.

In a June 5, 2014 report, Dr. Ellis reported on the history of injuries, noted his review of medical records, and presented findings examination. He reported diagnoses due to OWCP file number xxxxx195 were fracture of the right index finger DIP joint, right carpal tunnel syndrome, and organic depression. Diagnoses due to OWCP file number xxxxx335 were bilateral wrist tendinitis with carpal tunnel syndrome; bilateral triggering of the thumbs; bilateral medial epicondylitis; bilateral olecranon bursitis; bilateral cubital tunnel syndrome; bilateral radial tunnel syndrome, bilateral traumatic arthritis, tendinitis and osteoarthritis of the shoulders; bilateral reflex spasm of the neck and shoulder girdles causing bilateral brachial plexus impingement and neuritis. Dr. Ellis opined that appellant reached maximum medical improvement on September 3, 2013 when she was examined by Dr. Butler for a second opinion. Using the sixth edition of the A.M.A., *Guides*, he opined that she had a total combined impairment of 18 percent for the right upper extremity and total combined impairment of 17 percent of the left upper extremity. These were comprised of diagnosed-based and peripheral nerve impairments, for which Dr. Ellis cited to sections of the A.M.A., *Guides* and set forth his impairment methodology and calculations.

Appellant submitted several letters inquiring about the status of his reconsideration request.

By decision dated March 10, 2015, OWCP denied modification of its March 4, 2014 decision. It found that Dr. Ellis' reports were not probative and although additional evidence was submitted for consideration, Dr. Ellis had not provided sufficient rationalization for his findings or applied the A.M.A., *Guides* correctly.

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]

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). For upper and lower extremity impairments, the evaluator identifies the impairment Class of

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id.* at § 10.404(a).

Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[7] Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[8]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text in section 15.4f of the A.M.A., *Guides*.[9] In Table 15-23, grade modifiers levels (ranging from 0 to 4) are described for the categories test findings, history, and physical findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating value may be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities.[10]

ANALYSIS

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

Appellant was granted a schedule award for five percent permanent impairment of the right upper extremity, and five percent permanent impairment of the left upper extremity. The schedule award was based on the September 3, 2013 report of Dr. Butler, OWCP's second opinion physician. Dr. Butler examined appellant and reviewed a statement of accepted facts along with the medical record. He provided extensive findings examination and diagnosed cervical degenerative disc disease with C6 radiculopathy by EMG, clinically normal; bilateral shoulder sprain/strain resolved, bilateral medial epicondylitis, resolved, bilateral carpal tunnel syndrome, operated, stable; right thumb trigger finger, operated, resolved; and depression disorder. Dr. Butler opined that appellant reached maximum medical improvement on January 8, 2013. Under the sixth edition of the A.M.A., *Guides*, he opined that she had five percent right upper extremity impairment and five percent left upper extremity impairment. For the right upper extremity, the abnormal findings were based on right carpal tunnel syndrome, which Dr. Butler evaluated under Table 15-23, page 449. Test findings yielded grade modifier of 1 and grade modifiers of 2 were assigned to history and physical findings, for a total grade modifier of 5 and average 1.66. Dr. Butler noted that appellant had a *Quick*DASH of 48, which was moderate, so no modification was needed. He concluded that, based on these findings, she had an average grade modifier of 2, which had a default value of five percent impairment. Under the Combined Values Chart, Dr. Butler combined five percent (right wrist) with zero percent (right thumb, right elbow, and right shoulder) and found appellant had total five percent right upper extremity impairment rating.

[7] *R.Z.*, Docket No. 10-1915 (issued May 19, 2011).

[8] *J.W.*, Docket No. 11-289 (issued September 12, 2011).

[9] A.M.A., *Guides* 433-50.

[10] *Id.* at 448-50.

For the left upper extremity, Dr. Butler provided the following calculations: For left carpal tunnel syndrome: under Table 15-23, page 449, grade 1 was provided for clinical study findings; grade 2 was provided for history with significant intermittent symptoms; and grade 2 physical findings was provided for mildly decreased sensation. The grade modifier total was 5, with 1.66 average. Dr. Butler selected a grade 2, which had a default value of five percent, and noted no modifications were needed as the *Quick*DASH score of 48, was moderate and did not require modifications needed. Therefore, appellant has five percent left upper extremity impairment rating. Dr. Butler concluded that her other left upper extremity diagnoses yielded normal findings and zero percent impairment.

On October 18, 2013 the medical adviser reviewed the medical record including Dr. Butler's report. He advised that maximum medical improvement was obtained January 8, 2013, the date that Dr. Ellis examined appellant. The medical adviser agreed with Dr. Butler's assessment under the various tables cited in the A.M.A., *Guides* and in Dr. Butler's impairment calculations for the upper extremities.

Appellant had initially submitted Dr. Ellis' January 8, 2013 report wherein he concluded that appellant had 32 percent impairment to the right upper extremity and 28 percent impairment to the left upper extremity, the medical adviser reviewed this report and noted numerous areas of concern. These pertained to Dr. Ellis' characterization of the index finder impairment as upper extremity impairment, the inclusion of diagnoses that were not validated by the record, multiple diagnoses not included as accepted conditions and questionable classification of the EMG/NCV studies.

In his July 25, 2014 request for reconsideration, appellant submitted a June 5, 2014 report from Dr. Ellis, which addressed the concerns raised by the prior review of his January 8, 2013 report by the OWCP medical adviser. In his June 5, 2014 report, Dr. Ellis reported examination findings, opined that appellant had an increased impairment over the five percent left upper extremity and five percent right upper extremity impairment awarded, and explained his methodology for impairment calculation under the A.M.A., *Guides.* He noted in detail how he calculated her impairments under different tables of the A.M.A., *Guides*. OWCP did not refer this June 5, 2014 report for further review by an OWCP medical adviser, but denied modification of the schedule award, with a vague finding that this report did not provide sufficient rationale and did not apply the A.M.A., *Guides* correctly. The Board finds, therefore, that it erroneously denied modification of appellant's request for reconsideration without having this report reviewed by an OWCP medical adviser, or without requesting that Dr. Ellis address further information it believed was missing from his June 5, 2014 report.[11] On remand OWCP shall provide Dr. Ellis' July 25, 2014 to an OWCP medical adviser for a full and proper review as discussed above.

Proceedings under FECA are not adversarial in nature, nor was OWCP a disinterested arbiter. While the claimant has the responsibility to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence. It has the obligation to see that

[11] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f)(2)(c) (February 2013).

justice is done. Accordingly, once OWCP undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.

On remand, OWCP should further develop the medical evidence pursuant to this decision and issue an appropriate decision regarding her request for an increased schedule award.

CONCLUSION

The Board finds that the case is not in posture.

ORDER

IT IS HEREBY ORDERED THAT the March 10, 2015 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: December 7, 2015
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

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