United States Department of Labor
Employees' Compensation Appeals Board

G.T., Appellant	)	
and	)	**Docket No. 15-1803**
	)	**Issued: February 23, 2016**
U.S. POSTAL SERVICE, GRAND SHELBY STATION, Detroit, MI, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On August 31, 2015 appellant filed a timely appeal from an April 15, 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 met his burden of proof to establish more than two percent impairment of the left upper extremity for which he received a schedule award.

On appeal appellant asserts that he has established permanent impairment of his left elbow condition.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

In a claim adjudicated by OWCP under file number xxxxxx516, on May 6, 2006 appellant, then a 50-year-old city left carrier, filed a Form CA-1, traumatic injury claim, alleging that he injured his left elbow moving a large container. In a file adjudicated by OWCP under file number xxxxxx888, on April 24, 2007 he filed a Form CA-2, occupational disease claim, alleging that repeated stress caused shoulder and wrist problems.

On July 16, 2007 OWCP accepted bilateral carpal tunnel syndrome under file number xxxxxx888. On February 20, 2008 it accepted left elbow medial epicondylitis under file number xxxxxx516. Appellant filed schedule award claims under each file number.

In a decision dated October 9, 2008, OWCP denied appellant's schedule award claim under file number xxxxxx888.

In a claim adjudicated by OWCP under file number xxxxxx123, on December 27, 2010 appellant filed an occupational disease claim alleging that employment factors caused shoulder, neck, and hand pain.

On December 27, 2010 appellant submitted an additional schedule award claim under file number xxxxxx888. By letter dated January 13, 2011, OWCP informed him that it had received no additional medical evidence since the October 9, 2008 decision and concluded that the schedule award remained denied. Appellant thereafter submitted an August 8, 2012 electrodiagnostic study that revealed bilateral carpal tunnel syndrome, and treatment notes from Dr. Jeffrey M. Hall, Board-certified in surgery and hand surgery, dated July 16, 2012 to February 18, 2013. Dr. Hall, who began treating appellant in 2007, diagnosed chronic mild bilateral carpal tunnel syndrome and advised that appellant could work without restrictions. On February 18, 2013 he indicated that appellant planned to retire. Dr. Hall did not provide an impairment evaluation.

Under file number xxxxxx123, following an initial denial of appellant's claim on April 4, 2011, on September 12, 2011 OWCP set aside the April 4, 2011 decision and accepted bilateral shoulder bursitis.

On June 6, 2013 appellant filed schedule award claims under file numbers xxxxxx516 and xxxxxx123.

Under file number xxxxxx123, on September 13, 2013 OWCP referred appellant to Dr. Emmanuel N. Obianwu, a Board-certified orthopedic surgeon, for a second-opinion evaluation regarding whether appellant was entitled to a schedule award for the accepted bilateral shoulder bursitis. The statement of accepted facts (SOAF) and questions provided Dr. Obianwu referenced file number xxxxxx123 and that bilateral shoulder bursitis was accepted.

In an October 4, 2013 report, Dr. Obianwu described appellant's job duties and his review of the SOAF and medical record provided. He indicated that appellant had right shoulder pain and negligible symptoms regarding the left shoulder. Dr. Obianwu reported examination findings for the shoulders, which demonstrated full range of motion of both shoulders with pain and tenderness on the right. He diagnosed chronic bursitis and old rotator cuff tear of the right

shoulder and a normal left shoulder. Dr. Obianwu advised that appellant had reached maximum medical improvement on December 31, 2012. He provided an impairment analysis for the right shoulder in accordance with Table 15-5, Shoulder Regional Grid, of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*).[2] Dr. Obianwu found a class 1 impairment, applied the net adjustment formula, and concluded that appellant had six percent right upper extremity impairment, based on a diagnosis of rotator cuff tear. He found no impairment on the left.

On October 31, 2013 Dr. Morley Slutsky, an OWCP medical adviser Board-certified in occupational medicine, reviewed the xxxxxx123 record, including Dr. Obianwu's report. He agreed with Dr. Obianwu's conclusions regarding the date of maximum medical improvement and his right upper extremity impairment finding.

Under file number xxxxxx888, in November 2013 OWCP referred appellant to Dr. Allen L. Babcock, Board-certified in orthopedic surgery, for a second-opinion impairment evaluation regarding the accepted conditions of bilateral carpal tunnel syndrome. The SOAF and questions provided by Dr. Babcock referenced file number xxxxxx888 and that bilateral carpal tunnel syndrome was the accepted condition.

In a January 28, 2014 report, Dr. Babcock noted that appellant had retired in July 2013 and had a continued complaint of numbness and tingling that occurred mainly at night. He described his review of the medical record, including the August 8, 2012 electrodiagnostic study. Physical examination demonstrated full range of motion of the cervical spine and both upper extremities, including both hands, and no sign of atrophy. Tinel's was mildly positive at the right wrist and elbow. Dr. Babcock diagnosed stable bilateral carpal tunnel syndrome. He opined that appellant had reached maximum medical improvement and provided an impairment rating in accordance with Table 15-23, Entrapment/Compression Neuropathy, of the A.M.A., *Guides*. Dr. Babcock found a functional history modifier of one for mild symptoms, a physical examination modifier of two for decreased sensation, and a clinical studies modifier of one based on mild motor and sensory delays. Dr. Babcock averaged these values and found that appellant had two percent impairment of each arm due to carpal tunnel syndrome.

On March 18, 2014 Dr. Slutsky, the OWCP medical adviser, indicated that he reviewed all records, for file numbers xxxxxx123, xxxxxx888, and xxxxxx516.[3] He advised that appellant had a combined right upper extremity impairment of eight percent, based on Dr. Obianwu's finding of six percent for the right shoulder, and Dr. Babcock's assessment of two percent for right carpal tunnel syndrome. Dr. Slutsky further found that appellant had two percent left upper extremity impairment for carpal tunnel syndrome, based on Dr. Babcock's assessment. He advised that maximum medical improvement regarding the right shoulder was reached on October 4, 2013, and that maximum medical improvement for carpal tunnel syndrome and left elbow epicondylitis was reached on January 28, 2014. Dr. Slutsky agreed with Dr. Babcock's impairment rating of two percent for each arm based on a diagnosis of carpal tunnel syndrome.

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

[3] OWCP combined file numbers xxxxxx888 and xxxxxx123 on May 16, 2014, with file number xxxxxx888 the master file. On April 16, 2015 file number xxxxxx516 was combined into file number xxxxxx888.

Regarding left elbow epicondylitis, he advised that the medical records did not provide a basis for rating impairment for this condition.

On December 4, 2014 appellant was granted a schedule award for a six percent right upper extremity (shoulder) impairment, for a total of 18.72 weeks, to run from October 4, 2013 to February 12, 2014. OWCP found the weight of the evidence rested with the opinion of Dr. Obianwu, as reviewed by the OWCP medical adviser. Appellant was issued a second schedule award that day, for two percent impairment of each upper extremity due to carpal tunnel syndrome. The award was for 12.48 weeks of compensation, to run from January 28 to April 25, 2014.

On January 21, 2015 appellant requested reconsideration of each December 4, 2014 schedule award. He alleged that Dr. Babcock's report was not complete. Appellant submitted a January 13, 2015 report in which Dr. Stephanie Muh, a Board-certified orthopedic surgeon, noted that appellant was seen for evaluation of his left elbow. Dr. Muh reported that appellant complained of left elbow pain, especially with resting the elbow on a hard surface and had noticed prominence over the posterior aspect of the elbow. On elbow examination she found a bony prominence (osteophyte) over the posterior olecranon that was slightly painful to palpation, and full elbow range of motion. Dr. Muh advised that she could not determine if appellant's elbow condition was caused by employment injuries as she had no records to review, but that it could have resulted from trauma.

In a merit decision dated April 15, 2015, OWCP denied modification of the prior schedule award decisions. It found that, as Dr. Muh had not related appellant's current condition to employment injuries, causal relationship was not established, and there was no indication for an increased impairment rating.

LEGAL PRECEDENT

The schedule award provision of FECA, and its implementing federal regulation,[4] 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.[5] For decisions issued after May 1, 2009, the sixth edition will be used.[6]

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

[4] 20 C.F.R. § 10.404.

[5] *Id*. at § 10.404(a).

[6] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

and Health (ICF).[7] Under the sixth edition, for upper extremity impairments the evaluator identifies the impairment for the Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[8] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[9]

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*.[10] In Table 15-23, grade modifier 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.[11]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[12]

ANALYSIS

On appeal appellant is not contesting his right upper extremity schedule award. Rather, he asserts that he is entitled to additional left upper extremity impairment due to an accepted elbow condition. OWCP accepted left elbow medial epicondylitis on February 20, 2008. The Board finds this case is not in posture for decision regarding whether appellant has established permanent impairment for the accepted left elbow epicondylitis.

[7] 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."

[8] *Id*. at 385-419.

[9] *Id*. at 411.

[10] *Id*. at 433-50.

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

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

On December 4, 2014 appellant was granted two schedule awards, the first six percent impairment for his right shoulder. The second December 4, 2014 schedule award was for two percent impairment of each upper extremity due to carpal tunnel syndrome.[13]

As noted by Dr. Slutsky in his March 18, 2014 report, the medical records do not provide a basis for an impairment rating for this condition. OWCP did not inform either Dr. Obianwu or Dr. Babcock that appellant had an accepted left elbow condition in the questions or the SOAF that it had provided the physicians. Dr. Obianwu restricted his examination to the shoulders only. Dr. Babcock was referred to evaluate impairment for bilateral carpal tunnel syndrome. While Dr. Muh provided left elbow examination findings, she was not advised that appellant had an accepted left elbow medical epicondylitis.

Section 15.8 of the A.M.A., *Guides* provides guidance for evaluation of multiple upper extremity impairments.[14] The evaluator is to determine the diagnoses for each region and those to be rated, then determine the diagnosis-based impairments for each ratable diagnosis using the regional grids and applying the net adjustment formula. The diagnosis-based impairment ratings for the multiple diagnoses are to be combined, as shown in Figure 15-31,[15] with any additional impairments as identified in Figure 15-31, also combined to determine a total upper extremity impairment.

It is well established that proceedings under FECA are not adversarial in nature, and while the claimant has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[16] Once OWCP undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues of the case.[17] In this case, OWCP accepted left elbow medial epicondylitis. The Board finds that because no OWCP referral physician was asked to address appellant's accepted left elbow condition, the case is not in posture for decision and must be remanded to OWCP. On remand, OWCP should obtain an impairment rating regarding whether appellant has a ratable impairment due to the accepted left elbow epicondylitis. After this and such further development

[13] Although appellant did not specifically challenge the left upper extremity schedule award for carpal tunnel syndrome in his appeal to the Board, a review of Dr. Babcock's January 28, 2014 report shows that he properly provided an impairment rating in accordance with Table 15-23, Entrapment/Compression Neuropathy, of the A.M.A., *Guides*. Dr. Babcock found a functional history modifier of one for mild symptoms, a physical examination modifier of two for decreased sensation, and a clinical studies modifier of one based on mild motor and sensory delays. He properly averaged these values and found that appellant had two percent bilateral upper extremity impairment due to carpal tunnel syndrome. Dr. Slutsky, the OWCP medical adviser, reviewed Dr. Babcock's report and agreed with his conclusion that appellant had two percent left upper extremity impairment due to carpal tunnel syndrome. There is no medical evidence in accordance with the A.M.A., *Guides* to support that appellant is entitled to an additional award for left carpal tunnel syndrome.

[14] A.M.A., *Guides*, *supra* note 2 at 478-81.

[15] *Id*. at 480.

[16] *See Jimmy A. Hammons*, 51 ECAB 219 (1999); *John J. Carlone*, 41 ECAB 354 (1989).

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

deemed necessary, OWCP shall issue an appropriate merit decision on the issue of appellant's entitlement to an additional left upper extremity schedule award for this accepted condition.[18]

CONCLUSION

The Board finds this case is not in posture for decision regarding whether appellant is entitled to an additional schedule award for an accepted left elbow epicondylitis.

ORDER

IT IS HEREBY ORDERED THAT the April 15, 2015 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded to OWCP for proceedings consistent with this opinion of the Board.

Issued: February 23, 2016
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[18] *See M.D.*, Docket No. 13-503 (issued September 19, 2013).