United States Department of Labor
Employees' Compensation Appeals Board

L.S., Appellant	)	
and	)	**Docket No. 15-1564**
	)	**Issued: March 4, 2016**
U.S. POSTAL SERVICE, POST OFFICE, Southeastern, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., 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 July 13, 2015 appellant, through counsel, filed a timely appeal from a March 11, 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 the case.

ISSUE

The issue is whether appellant is entitled to a schedule award greater than 23 percent to her right upper extremity, for which she has received an award.

On appeal, counsel argues that OWCP improperly evaluated the medical evidence, and that at the very least, referral for an impartial medical examination is necessary.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On March 13, 2003 appellant, then a 51-year-old clerk, filed an occupational disease claim (Form CA-2) alleging that after returning to work on October 15, 2002, following a July 8, 2002 right carpal tunnel release, her symptoms recurred. On July 14, 2003 OWCP accepted her claim for proximal radiculitis with bilateral brachial plexitis. The record reflects that appellant had a previously accepted claim for bilateral carpal tunnel syndrome in OWCP File No. xxxxxx734. Appellant previously received a schedule award for 23 percent of each upper extremity based on accepted bilateral carpal tunnel syndrome in OWCP File No. xxxxxx734. The prior schedule award was calculated according to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (fifth edition 2001).

On October 30, 2013 appellant filed a claim for a schedule award (Form CA-7).

In a May 6, 2011 report, Dr. Arthur Becan, an orthopedic surgeon, evaluated appellant under the sixth edition of the A.M.A., *Guides* (6th ed. 2009). He determined that pursuant to Table 15-20, appellant had a class 2 Class of Diagnosis (CDX) severe sensory deficit right brachial plexus (upper trunk) which equaled 18 percent impairment.[2] Dr. Becan listed grade modifiers 3 for Functional History (GMFH) (based on a *Quick*DASH of 79 percent), and grade modifiers 1 for Clinical Studies (GMCS). Applying the formula set forth in the A.M.A., *Guides*, (GMFH-CDX) + (GMCS-CDX) = net adjustment, he determined that GMFH-CDX (3-2) =1, and GMCS-CDX (1-2) = -1, and adding these sums together yielded a net adjustment of 0, which left appellant with no grade modification, and a right upper extremity impairment after net adjustment of 18 percent. Dr. Becan next evaluated her severe sensory deficit right brachial plexus (middle trunk), which he found equaled a class 1 CDX of four percent pursuant to Table 15-20.[3] He then applied grade modifiers 3 for GMFH and 1 for GMCS. Applying the formula Dr. Becan determined that GMFH-CDX (3-1) = 2; GMCS-CDX (1-1) = 0. Adding 0 + 2 = 2, he noted a net adjustment of 2, which yielded a right upper extremity impairment of four percent. Dr. Becan then considered entrapment neuropathy right median nerve under Table 15-23,[4] and noted test findings of 1, history of 3, and physical examination (decreased pinch) of 3, which equaled a total of 7, average 3, which equaled an eight percent impairment. He then noted that GMFH (*Quick*DASH of 79 percent) equaled 3, so the impairment remained 8 percent. Dr. Becan then combined the findings of 18 percent, 4 percent and 8 percent, and determined that appellant had 28 percent permanent impairment of the right upper extremity. With regard to the left upper extremity, he found an impairment of 22 percent.

By letter dated September 4, 2013, counsel argued that an award be given for the right extremity for the difference between the 23 percent previously award and 28 percent found by Dr. Becan when he rated both of the accepted conditions of carpal tunnel syndrome and brachial plexopathy. Counsel did not request an extra award for impairment to the left upper extremity.

[2] A.M.A., *Guides* 434, Table 15-20.

[3] *Id.* at 435.

[4] *Id.* at 449.

On November 4, 2013 OWCP referred appellant's case to its medical adviser for evaluation of appellant's impairment rating. In response, the medical adviser noted that appellant was previously issued a schedule award for 23 percent permanent impairment of each upper extremity, and that the additional award by Dr. Becan was based on a class 2 severity right brachial plexus impairment of 18 percent which was inconsistent with the clinical findings. Accordingly, she determined that appellant was not entitled to a greater schedule award.

By decision dated December 2, 2013, OWCP denied appellant's claim for an additional schedule award.

On December 9, 2013 appellant, through counsel, requested a hearing.

In an April 2, 2014 decision, the hearing representative remanded the case. She found that this case should be combined with File No. xxxxxx734, and that appellant should then be referred to an appropriate Board-certified specialist to perform an assessment in conformance with the sixth edition of the A.M.A., *Guides.*

On April 7, 2014 OWCP doubled the cases in File Nos. xxxxxx429 and xxxxxx734 (master).

On April 8, 2014 OWCP referred appellant to Dr. Noubar A. Didizian, a Board-certified orthopedic surgeon, for a second opinion. In reports dated June 4, 2014, Dr. Didizian noted that she had previously received 46 percent bilateral upper extremity impairment for bilateral carpal tunnel. He noted that this brachial neuritis claim has been combined with the carpal tunnel claim to ascertain if there is any combined additional impairment. Dr. Didizian noted that, based on his examination and review of the record, he did not find any evidence of brachial plexopathy or neuritis, and appellant's carpal tunnel syndromes had minimal sensory loss. In his supplemental report of the same date, he noted that, for bilateral carpal tunnel syndrome, status postsurgery, he used Table 15-23 of the A.M.A., *Guides* and found that the test findings indicating positive electromyogram (EMG) gave appellant a grade modifier 1 for sensory and/or motor loss; for history mild intermittent symptoms indicated a grade modifier 1; and for physical findings a grade modifier 1 was due to very mild findings. Dr. Didizian noted a normal functional scale. Adding these figures for test findings, history, and physical findings, he found a sum of 3, which divided by 3 is 1. Dr. Didizian indicated that the default percentage under grade modifier 1 of Table 15-23 was two percent. He noted that *Quick*DASH was normal and therefore had a value of 0. Dr. Didizian noted that this is one less than the calculated grade modifier 1 and therefore would shift the percentage to the left for a final percentage of one percent for each upper extremity, for a combined upper extremity impairment of two percent.

Dr. Didizian continued that, as far as brachial neuritis was concerned, the same methodology was used in Table 15-23. He noted that the test findings with EMG were grade modifier 1, history of mild intermittent symptoms would be grade modifier 1, and physical findings were normal and would also be grade modifier 1. Dr. Didizian noted calculation of a final grade modifier 1 with a default percentage of two percent of the upper extremities. Since only one diagnosis received the full percentage, and both diagnoses were rated at two percent impairment, he found that the carpal tunnel syndrome was more significant and would remain two percent impairment, while brachial plexus will be calculated at a level of 50 percent as a second neuropathy, as indicated on page 448 of the A.M.A., *Guides*. Dr. Didizian therefore

concluded that appellant had a combination of bilateral carpal tunnel two percent upper extremity impairment combined with the brachial neuritis of one percent totaling three percent permanent impairment for each upper extremity.

On July 16, 2014 OWCP asked the medical adviser to comment on the impairment rating. The medical adviser found that the average of grade modifiers (test results, history and physical examination) rounded to the nearest integer equaled one. He noted that the default upper extremity impairment was two percent permanent impairment of each upper extremity. The medical adviser noted that, as the functional scale was normal, he adjusted the rating to the left by one value for a final bilateral upper extremity impairment of one percent.

By decision dated July 22, 2014, OWCP denied appellant's claim for a greater award.

At the hearing held on December 22, 2014, counsel argued that Dr. Didizian's report was too poorly reasoned to carry the weight of the evidence, and that at the very least Dr. Didizian's report was in conflict with the reports of appellant's physician.

By decision dated March 11, 2015, OWCP denied appellant's claim for an increased schedule award. The hearing representative found that the weight of the evidence was represented by the opinion of the OWCP medical adviser.

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing regulations[6] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for 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 insure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[7] The effective date of the sixth edition of the A.M.A., *Guides* is May 1, 2009.[8]

The sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.[9] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[10]

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id.*

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

[9] A.M.A., *Guides* 494-531.

[10] *Id.* at 521.

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the 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.[11]

Section 8123(a) provides that, if there is a disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[12] The implementing regulations state that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[13] In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationale and based upon a proper factual background, must be given special weight.[14]

ANALYSIS

Appellant previously received a schedule award for 23 percent permanent impairment of each upper extremity. She now asks for an increased award to her right upper extremity.

Appellant's treating physician, Dr. Becan, determined that appellant was previously awarded 23 percent permanent impairment to each upper extremity based on carpal tunnel syndrome. However, he calculated that she was entitled to 28 percent impairment of the right upper extremity, after adjustments are made for sensory deficit for right branchial plexus and entrapment neuropathy to the right nerve. Dr. Didizian the second opinion physician disagreed and determined that appellant was not entitled to a greater award, finding that she had only three percent total upper extremity impairment. Appellant's case was sent to the medical adviser for review. He determined that she had only one percent permanent impairment of the right upper extremity. OWCP determined that the weight of the evidence was represented by the opinion of the medical adviser.

The Board finds that there is an unresolved conflict in the medical evidence. Dr. Becan, who made an impairment evaluation on behalf of appellant, determined that she had 28 percent permanent impairment. Dr. Didizian, the second opinion physician, found that she had a total of three percent permanent impairment of the upper extremities. The medical adviser determined that appellant had one percent bilateral upper extremity impairment. If there is disagreement between OWCP's referral physician and appellant's physician, OWCP will appoint a third physician who shall make an examination.[15] For a conflict to arise, the opposing physician's

[11] *See supra* note 8 at Chapter 2.808.6(f) (February 2013).

[12] *R.C.*, Docket No. 12-437 (issued October 23, 2012).

[13] 20 C.F.R. § 10.321.

[14] *F.C.*, Docket No. 14-0560 (issued November 12, 2015).

[15] 5 U.S.C. § 8123(a); *see Y.A.*, 59 ECAB 701 (2008).

viewpoints must be of virtually equal weight and rationale.[16] The Board finds that the opinions of Dr. Becan and Dr. Didizian are of equal weight and presented a conflict in the medical evidence. OWCP erred when it gave decisive weight to the opinion of the medical adviser. While an OWCP medical adviser may create a conflict in medical opinion, he or she may generally not resolve it.[17]

The Board finds that a conflict exists in the medical evidence with regard to the amount of appellant's impairment of her right upper extremity. The Board will remand the case for referral to an impartial medical specialist for resolution of the conflict in the medical opinion evidence. After such further development as OWCP deems necessary, it shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for decision due to an unresolved conflict in the medical opinion evidence.

ORDER

IT IS HEREBY ORDERED THAT the March 11, 2015 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further consideration consistent with this opinion.

Issued: March 4, 2016
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

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

[17] *See S.J.*, Docket No. 15-1500 (issued November 3, 2015).