United States Department of Labor
Employees' Compensation Appeals Board

J.J., Appellant	)	
and	)	**Docket No. 16-0422**
	)	**Issued: October 6, 2016**
FEDERAL COMMUNICATIONS COMMISSION (FCC), Oakdale, LA, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 4, 2016 appellant, through counsel, filed a timely appeal from an October 22, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has met her burden of proof to establish more than one percent permanent impairment to her left upper extremity, for which she received a schedule award.[3]

FACTUAL HISTORY

On May 8, 2008 appellant, then a 49-year-old senior case manager, filed an occupational disease claim (Form CA-2) alleging that her trigger finger condition was caused or aggravated by excessive typing. OWCP accepted the claim for the condition of bilateral trigger finger and paid appropriate compensation benefits. Appellant underwent right fourth trigger finger release on the left hand on March 27, 2008 and on the right hand on April 24, 2008 performed by Dr. Angela Mayeux-Hebert, her treating Board-certified orthopedic surgeon.

On July 2, 2012 counsel submitted a claim for compensation (Form CA-7) requesting schedule award compensation.

In a July 8, 2011 report, Dr. M. Stephen Wilson, an orthopedic surgeon, noted appellant's history of injury and that she underwent fourth trigger finger release on the left hand on March 27, 2008 and on the right hand on April 24, 2008. He reviewed her medical records and presented examination findings of chronic changes in left and right ring fingers with pain, weakness, and intermittent triggering. Dr. Wilson opined that appellant reached maximum medical improvement (MMI). Utilizing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[4] (A.M.A., *Guides* hereinafter), and citing to tables and figures, he opined that she sustained six percent digit impairment or two percent hand impairment or two percent upper extremity impairment to both the left and right extremities. Under Table 15-2, Dr. Wilson found that appellant had class 1 triggering of the ring finger requiring surgery with a default value of six percent digit impairment. Under Tables 15-7 through 15-9, grade modifiers were assessed as grade 1 for functional history, grade 1 for physical examination, and nonapplicable for clinical studies. A net adjustment of 0 was found under the net adjustment formula, (GMFH - CDX)(1-1) + (GMPE - CDX)(1-1) + (GMCS - CDX) (N/A), which resulted in six percent impairment to the digit. Dr. Wilson opined that six percent digit impairment was equivalent to two percent hand impairment or two percent upper extremity impairment.

On October 20, 2014 an OWCP medical adviser reviewed the record, the statement of accepted facts (SOAF) and Dr. Wilson's July 8, 2011 impairment report. He agreed with Dr. Wilson's impairment calculations of six percent ring digit for the left and right, but indicated under Table 15-12, page 421, six percent ring digit equaled one percent upper extremity impairment, not two percent upper extremity impairment as indicated by Dr. Wilson. The medical adviser noted that a review of the record indicated that, in a September 15, 2009 report,

[3] Based on the evidence of record, the schedule award should have been issued for the right upper extremity, not the left upper extremity. The Board will treat this as a typographical error on OWCP's part.

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

Dr. Mayeux-Hebert indicated that "physical exam[ination] of the left hand shows that the scars have healed to the point that I can[no]t find them. [Appellant] has no scarring in her palm. She had no triggering. [Appellant's] right hand also shows fair grip strength. She does have early triggering of the right index finger." The medical adviser opined that Dr. Mayeux-Hebert's examination of September 15, 2009 appeared to conflict with Dr. Wilson's July 8, 2011 examination findings and recommended that appellant undergo a second opinion examination.

Based on the deficiencies noted by OWCP's medical adviser, OWCP referred appellant to Dr. Brett Rothaermel, Board-certified in physical medicine and rehabilitation, for a second opinion impairment rating. In a December 11, 2014 report, Dr. Rothaermel noted the history of injury, his review of the medical records and the SOAF, and presented examination findings. He found full range of motion and strength throughout bilateral hands and upper extremities and indicated that appellant had the normal ability to reach, push, pull, grasp, and perform fine and gross motor movements. There was also normal muscle bulk and tone throughout the hands. Dr. Rothaermel opined that she was at MMI. For the right upper extremity, he found diagnostic classification of digital stenosing tenosynovitis under Table 15-2, page 392, was class 1 with default value of six percent digit impairment. Under Tables 15-7 through 15-9, grade modifiers were provided along with an explanation. A grade 2 modifier was provided for Functional History (GMFH), a grade modifier 0 was provided for Physical Examination (GMPE), and grade modifier 1 was provided for Clinical Studies (GMCS). A net adjustment of 0 was found under the net adjustment formula, (GMFH - CDX)(2-1) + (GMPE - CDX)(0-1) + (GMCS - CDX)(1-1), which resulted in six percent impairment to the right digit.

For the left upper extremity, Dr. Rothaermel found diagnostic classification of digital stenosing tenosynovitis under Table 15-2, page 392, was class 1 with default value of six percent digit impairment. Under Tables 15-7 through 15-9, grade modifiers were provided along with an explanation. A grade modifier for GMFH was not applicable as it was utilized for the right upper extremity, a grade modifier 0 was assigned for GMPE, and a grade modifier 1 was assigned for GMCS. A net adjustment of -1 was found under the net adjustment formula, (GMFH - CDX) (N/A) + (GMPE - CDX)(0-1) + (GMCS - CDX)(1-1), which resulted in five percent digit impairment.

On February 20, 2015 an OWCP medical adviser reviewed Dr. Rothaermel's December 5, 2014 impairment report. He opined that appellant reached MMI on December 5, 2014, the date of Dr. Rothaermel's evaluation. The medical adviser opined that Dr. Rothaermel correctly applied the A.M.A., *Guides* to his impairment findings. He noted, in evaluating Dr. Rothaermel's report, that he inverted his findings for the left upper extremity and the right upper extremity. The medical adviser also related that Dr. Rothaermel did not convert the digit impairments to upper extremity impairment. Under Table 15-12, page 421, he converted the six percent right digit impairment to one percent right upper extremity permanent impairment and the five percent left digit impairment to zero percent left upper extremity permanent impairment.[5]

[5] The medical adviser mislabeled the left and right extremity findings.

By decision dated October 22, 2015, OWCP granted appellant a schedule award for one percent left upper extremity.[6] The award ran 3.12 weeks from December 5 to 26, 2014.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations 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.[7] 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 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.[8]

The A.M.A., *Guides* provide a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning (ICF), Disability, and Health.[9] In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated. After the Class of Diagnosis (CDX) is determined for the diagnosed condition (including identification of a default grade value), the net adjustment formula is applied using the GMFH, GMPH, and GMCS.[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[12]

In the sixth edition, diagnosis-based impairment (DBI) is the primary method of evaluation for the upper extremity. A grid listing relevant diagnoses is provided for each region of the upper extremity: the digit region, the wrist region, the elbow region, and the shoulder region. A regional impairment will be defined by class and grade. The class is determined first by using the corresponding regional grid. The grade is initially assigned the default value for that class. This value may be adjusted slightly using nonkey grade modifiers such as GMFH,

[6] *See supra* note 3. The schedule award should have been issued for right upper extremity, not the left upper extremity.

[7] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[8] *K.H.*, Docket No. 09-341 (issued December 30, 2011). For decisions issued after May 1, 2009, the sixth edition will be applied. *B.M.*, Docket No. 09-2231 (issued May 14, 2010). Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); *id*. at Part 3 -- Claims, *Schedule Awards* Chapter 3.700, Exhibit 1 (January 2010).

[9] A.M.A., *Guides*, *supra* note 4, section 1.3, The ICF: A Contemporary Model of Disablement.

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

[11] *Id*. at 411.

[12] *Id.* at 23-28.

GMPE, and GMCS.[13] The sixth edition of the A.M.A., *Guides* also provides that, under certain circumstances, range of motion may be selected as an alternative approach in rating impairment. An impairment rating that is calculated using range of motion may not be combined with a DBI and stands alone as a rating.[14]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an 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.[15]

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.[16] 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.[17] 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.[18]

ANALYSIS

The Board finds that the weight of the medical evidence establishes that appellant has no more than one percent permanent impairment of her right upper extremity. The Board further finds that the case is not in posture as to the impairment of the left upper extremity due to a conflict in the medical opinion evidence.

OWCP accepted that appellant sustained bilateral trigger finger (acquired) conditions. Section 15.2 of the A.M.A., *Guides* provide that DBI is the primary method of evaluation for the upper extremities.[19] Table 15-2, Digit Regional Grid, is the appropriate table for use in finger impairments.[20]

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[13] *Id.* at 387.

[14] *Id.* at 390. The A.M.A., *Guides* explains that diagnoses in the grid that may be rated using range of motion are followed by an asterisk.

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

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

[17] 20 C.F.R. § 10.321.

[18] *See supra* note 15 at Chapter 2.808.11 (February 2013).

[19] A.M.A., *Guides* 387-90.

[20] *Id*. at 391-94.

In his July 8, 2011 report, Dr. Wilson presented examination findings of chronic changes in left and right ring fingers with pain, weakness, and intermittent triggering. He indicated that appellant reached MMI. Utilizing the sixth edition of the A.M.A., *Guides*,[21] and citing to tables and figures, Dr. Wilson also opined that appellant sustained impairment to both the right and left upper extremities. Under Table 15-2, he found that appellant had class 1 triggering of the ring finger requiring surgery with a default value of six percent digit impairment. Under Tables 15-7 through 15-9, grade modifiers were assessed as grade 1 for GMFH, grade 1 for GMPE, and nonapplicable for GMCS. A net adjustment of 0 was found under the net adjustment formula, (GMFH - CDX)(1-1) + (GMPE - CDX)(1-1) + (GMCS - CDX) (N/A), which resulted in six percent impairment to the digit. An impairment rating for a given digit is converted to an impairment rating for an upper extremity using Table 15-12 on pages 421 through 423.[22] While Dr. Wilson opined that six percent digit impairment was equivalent to two percent upper extremity impairment, the Board notes that under Table 15-12, page 421, six percent digit impairment equals one percent upper extremity impairment. Thus, he opined that appellant had one percent right upper extremity impairment and one percent left upper extremity impairment. The medical adviser reviewed Dr. Wilson's opinion and agreed that appellant had one percent right and one percent left upper extremity impairment. While he found Dr. Wilson's 2011 physical examination findings conflicted with a 2009 examination of record, the earlier report is stale and is therefore not a proper basis to discredit Dr. Wilson's impairment report.[23]

In his December 11, 2014 report, Dr. Rothaermel reviewed appellant's medical record, the SOAF, and presented examination findings. He properly utilized Table 15-2 in his impairment analysis. In accordance with Table 15-2, for a diagnosis of digital stenosing tenosynovitis,[24] appellant had class 1 impairment. For the right upper extremity, Dr. Rothaermel found under Tables 15-7 through 15-9, a grade 2 modifier for GMFH, a grade 0 modifier for GMPE, and grade 1 modifier for GMCS. A net adjustment of 0 was found under the net adjustment formula, (GMFH - CDX)(2-1) + (GMPE - CDX)(0-1) + (GMCS - CDX) (1-1), which resulted in six percent impairment to the right digit. For the left upper extremity, Dr. Rothaermel found diagnostic classification of digital stenosing tenosynovitis under Table 15-2, page 392, was class 1 impairment with default value of six percent digit impairment. Under Tables 15-7 through 15-9, he found a grade modifier for GMFH was not applicable as it was utilized for the right upper extremity, a grade 0 modifier for GMPE, and a grade 1 modifier for GMCS. A net adjustment of -1 was found under the net adjustment formula, (GMFH - CDX)(N/A) + (GMPE - CDX)(0-1) + (GMCS - CDX) (1-1), which resulted in five percent digit impairment. An OWCP medical adviser agreed with Dr. Rothaermel's digit impairment calculations and, under Table 15-12 converted the digit impairments to upper extremity impairments. For the right ring trigger finger, six percent digit impairment converts to one percent right upper extremity impairment. For the left ring finger, five percent digit impairment converts to zero percent left upper extremity impairment.

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

[22] *Id*. at 421-23, Table 15-12. *See also R.P.*, Docket No. 14-0883 (issued August 7, 2014).

[23] *See A.A.*, Docket No. 15-0898 (issued July 28, 2015).

[24] A.M.A., *Guides* 392.

With regard to the right upper extremity, the Board finds that Dr. Wilson, appellant's treating physician, and Dr. Rothaermel, an OWCP second opinion physician, both opined that appellant had one percent right upper extremity impairment. There is no other medical evidence of record to establish greater than the one percent right upper extremity permanent impairment, for which she has received a schedule award.[25]

With regard to the left upper extremity, there exists an unresolved conflict as to whether appellant established her entitlement to a schedule award between appellant's treating physicians and the physician who conducted the second opinion examination for OWCP. Dr. Wilson opined that she had one percent left upper extremity impairment, while Dr. Rothaermel opined that she had no left upper extremity impairment. The dispute between the physicians centers on varying opinions relative to the use of grade modifiers for GMFH and GMPE in the permanent impairment calculation. If there is disagreement between OWCP's referral physician and appellant's physician, OWCP will appoint a third physician who shall make an examination.[26] For a conflict to arise, the opposing physician's viewpoints must be of virtually equal weight and rationale.[27] The Board finds that the opinion of Dr. Wilson is of equal weight as the opinion of Dr. Rothaermel. Accordingly, there was an unresolved conflict in the medical evidence.

The Board finds that a conflict exists in the medical evidence with regard to the amount of appellant's impairment of her left 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.[28]

CONCLUSION

The Board finds that appellant has failed to establish more than one percent permanent impairment of the right upper extremity. The Board further finds that this case is not in posture for decision due to an unresolved conflict in the medical opinion evidence with regard to the left upper extremity impairment.

[25] *See L.C.*, Docket No. 14-1892 (issued February 2, 2015); *see also supra* note 2.

[26] 5 U.S.C. § 8123(a); *see Y.A.*, 59 ECAB 701 (2008).

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

[28] Due to the disposition of this case, appellant's arguments on appeal will not be addressed.

ORDER

IT IS HEREBY ORDERED THAT the October 22, 2015 decision of the Office of Workers' Compensation Programs is affirmed as modified in part and set aside in part and the case remanded for further consideration consistent with this opinion.

Issued: October 6, 2016
Washington, DC

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

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board