United States Department of Labor
Employees' Compensation Appeals Board

M.P., Appellant	)	
and	)	**Docket No. 15-1558**
	)	**Issued: April 13, 2017**
U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, Dallas, TX, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 13, 2015 appellant filed a timely appeal from an April 6, 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 claim.[2]

ISSUE

The issue is whether appellant has met his burden of proof to establish that he has more than 14 percent permanent impairment of each upper extremity for which he previously received schedule awards.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The record provided to the Board includes evidence received after OWCP issued its April 6, 2015 decision. The Board's review is limited to the evidence that was before OWCP at the time of its final decision. Therefore, the Board lacks jurisdiction to review this additional evidence. 20 C.F.R. § 501.2(c)(1).

FACTUAL HISTORY

Appellant, a 57-year-old training technician, has an accepted occupational disease claim (Form CA-2) for bilateral carpal tunnel syndrome, which arose on or about January 11, 2010. He underwent OWCP-approved right and left carpal tunnel releases on January 18 and April 28, 2011, respectively. Additional accepted conditions include brachial neuritis/radiculitis, cervicalgia, aggravation of cervical intervertebral disc displacement, bilateral shoulder/upper arm sprain, and bilateral shoulder region disorder of bursae and tendons.

By decision dated July 11, 2012, OWCP granted a schedule award for four percent bilateral upper extremity permanent impairment under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (2009). The award covered a period of 24.96 weeks, from February 23 to August 15, 2012. OWCP based the award on a report of a district medical adviser (DMA) who utilized the diagnosis-based impairment (DBI) method based for the diagnosis of bilateral compression neuropathy median nerve computerized tomography scan under Table 15-23, Entrapment/Compression Neuropathy Impairment, A.M.A., *Guides* 449 (6th ed., 2009). In a January 9, 2013 decision, it denied modification of its July 11, 2012 bilateral upper extremity schedule award.

On February 28, 2013 appellant underwent left shoulder arthroscopic surgery, which OWCP had authorized. Additionally, OWCP further expanded the claim to include bilateral ulnar nerve lesion, bilateral medial epicondylitis, bilateral brachial plexus lesion, lumbar sprain, lumbar/lumbosacral intervertebral disc degeneration, and lumbar spinal stenosis.

In October 2013, appellant returned to work in a part-time, limited-duty capacity.[3]

On February 11, 2014 appellant filed a claim for an increased schedule award (Form CA-7).

In a January 16, 2014 report, Dr. Ronnie D. Shade, a Board-certified orthopedic surgeon, provided examination findings and opined that appellant reached maximum medical improvement (MMI). He found 31 percent left upper extremity permanent impairment and 7 percent right upper extremity permanent impairment. The left upper extremity impairment included 17 percent for spinal nerve (C6, C7) extremity impairment, 11 percent shoulder range of motion (ROM) impairment, 5 percent for carpal tunnel syndrome, and 2 percent elbow (medial epicondylitis) impairment. With respect to appellant's right upper extremity, Dr. Shade similarly found five percent for carpal tunnel syndrome and two percent elbow (medial epicondylitis) impairment.

On March 18, 2014 Dr. Ronald Blum, a Board-certified orthopedic surgeon and OWCP DMA, reviewed the medical record, including Dr. Shade's January 16, 2014 report. The DMA identified what he perceived to be inconsistencies in the medical findings and consequently, recommended that OWCP refer appellant for a second opinion evaluation.

[3] By May 2014 appellant resumed his regular, full-time duties without restrictions.

OWCP subsequently referred appellant to Dr. Marvin E. Van Hal, a Board-certified orthopedic surgeon, who examined appellant on May 22, 2014.[4] In his June 2, 2014 report, Dr. Van Hal noted that he reviewed appellant's medical records, a statement of accepted facts, and performed his own physical examination. He advised that appellant reached MMI as of January 16, 2014, when Dr. Shade last examined appellant. Dr. Van Hal noted that appellant's elbow did not show any significant ROM deficits and there were no imaging studies of either elbow to confirm any abnormality. Dr. Van Hal further indicated that appellant already received a rating of four percent bilateral upper extremity permanent impairment due to carpal tunnel syndrome, which did not appear to require reassessment or further documentation.

As for other conditions affecting appellant's upper extremities, Dr. Van Hal noted that ROM methodology was the best technique to utilize for determining impairment of the shoulder. Under Table 15-34, shoulder ROM, A.M.A., *Guides* 475 (6th ed., 2009), he indicated that appellant had 10 percent left upper extremity permanent impairment. This was comprised of three percent impairment for forward flexion (130 degrees), one percent impairment for extension (30 degrees), three percent impairment for abduction (130 degrees), one percent impairment for adduction (20 degrees), zero percent impairment for external rotation (70 degrees), and two percent impairment for internal rotation (70 degrees). For the right shoulder, Dr. Van Hal found three percent impairment for flexion (150 degrees), one percent impairment for extension (30 degrees), three percent impairment for abduction (140 degrees), one percent impairment for adduction (20 degrees), zero percent impairment for external rotation (80 degrees), and two percent impairment for internal rotation (70 degrees). He indicated that no adjustment to the bilateral shoulder ROM impairments was indicated as appellant was functioning at regular duty.

For the bilateral elbow, Dr. Van Hal found that no impairment was necessary or appropriate as the diagnosis was not confirmed symptomatically, there was no magnetic resonance imaging (MRI) scan of an epicondylitis condition, or any documentation of an ongoing ulnar neuritis. For the cervical spine he found no basis for permanent impairment as no objective neurological deficit was found on clinical examination. Dr. Van Hal indicated that appellant's reflexes were symmetrical and his strength was normal except for the supraspinatus, which was related to his shoulder surgery and not due to his neck. Thus, he opined that appellant had zero percent permanent impairment of the C6 and C7 nerve roots. Dr. Van Hal concluded that the only impairment rating warranted was 10 percent each for the right and left upper extremities based on loss of shoulder ROM.

On July 23, 2014 Dr. Blum, the DMA, reviewed the medical record, including Dr. Van Hal's June 2, 2014 report. He indicated that MMI was achieved January 16, 2014. The DMA agreed with Dr. Van Hal that there was no need to reassess the previous four percent bilateral upper extremity permanent impairment rating for carpal tunnel syndrome. For loss of motion of the shoulders, Dr. Blum used Dr. Van Hal's clinical findings and similarly found 10 percent bilateral upper extremity impairment under Table 15-34, A.M.A., *Guides* 475 (6th ed., 2009).

[4] As part of his second opinion evaluation, Dr. Van Hal obtained additional x-rays and referred appellant for a functional capacity evaluation, which was performed on May 23, 2014.

By decision dated September 2, 2014, OWCP granted appellant a schedule award for an additional 10 percent permanent impairment of each upper extremity, for a total bilateral upper extremity impairment of 14 percent. The award covered a 62.4-week period from May 23, 2014 to August 2, 2015.

On December 16, 2014 appellant requested reconsideration. He submitted a September 29, 2014 report from Dr. Shade who indicated that contrary to Dr. Van Hal's finding of no cervical-related or bilateral elbow impairment, there was diagnostic testing and medical reports of record that confirmed elbow diagnoses and found impairment. Dr. Shade recommended that appellant be referred for an impartial medical evaluation.

OWCP also received additional progress reports from Dr. Shade, a March 29, 2014 cervical MRI scan, and an August 5, 2014 report from Dr. Benjamin C. Dagley, an osteopath specializing in physiatry, who provided ROM measurements for appellant's left shoulder. Additionally, it received a September 19, 2014 left elbow MRI scan.

By decision dated April 6, 2015, OWCP denied modification of its September 2, 2014 schedule award.

LEGAL PRECEDENT

Section 8149 of FECA delegates to the Secretary of Labor the authority to prescribe rules and regulations for the administration and enforcement of FECA. The Secretary of Labor has vested the authority to implement the FECA program with the Director of OWCP.[5] 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.[6] 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. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[7]

The sixth edition of the A.M.A., *Guides* was first printed in 2008. Within months of the initial printing, the A.M.A. issued a 52-page document entitled "Clarifications and Corrections, Sixth Edition, *Guides to the Evaluation of Permanent Impairment.*" The document included various changes to the original text, intended to serve as an *erratum*/supplement to the first printing of the A.M.A., *Guides*. In April 2009, these changes were formally incorporated into the second printing of the sixth edition.

[5] *See* 20 C.F.R. §§ 1.1-1.4.

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

[7] 20 C.F.R. § 10.404; *see also Ronald R. Kraynak*, 53 ECAB 130 (2001).

As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[8] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[9]

ANALYSIS

The issue on appeal is whether appellant has met his burden of proof to establish that he has greater than 14 percent permanent bilateral upper extremity impairment. The Board finds that this case is not in posture for decision.

The Board has found that OWCP has inconsistently applied Chapter 15 of the sixth edition of the A.M.A., *Guides* when granting schedule awards for upper extremity claims. No consistent interpretation has been followed regarding the proper use of the DBI or the ROM methodology when assessing the extent of permanent impairment for schedule award purposes.[10] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[11] In *T.H.*, the Board concluded that OWCP physicians are at odds over the proper methodology for rating upper extremity impairment, having observed attending physicians, evaluating physicians, second opinion physicians, impartial medical examiners, and district medical advisers use both DBI and ROM methodologies interchangeably without any consistent basis. Furthermore, the Board has observed that physicians interchangeably cite to language in the first printing or the second printing when justifying use of either ROM or DBI methodology. Because OWCP's own physicians are inconsistent in the application of the A.M.A., *Guides*, the Board finds that OWCP can no longer ensure consistent results and equal justice under the law for all claimants.[12]

In light of the conflicting interpretation by OWCP of the sixth edition with respect to upper extremity impairment ratings, it is incumbent upon OWCP, through its implementing regulations and/or internal procedures, to establish a consistent method for rating upper extremity impairment. In order to ensure consistent results and equal justice under the law for cases involving upper extremity impairment, the Board will set aside the April 6, 2015 decision. Following OWCP's development of a consistent method for calculating permanent impairment for upper extremities to be applied uniformly, and such other development as may be deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim for an upper extremity schedule award.

[8] *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 2.808.5a (February 2013).

[9] *Isidoro Rivera*, 12 ECAB 348 (1961).

[10] *T.H.*, Docket No. 14-0943 (issued November 25, 2016).

[11] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[12] *Supra* note 10.

CONCLUSION

The Board finds this case not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the April 6, 2015 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: April 13, 2017
Washington, DC

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

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

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