United States Department of Labor
Employees' Compensation Appeals Board

R.A., Appellant	)	
and	)	**Docket No. 16-0016**
	)	**Issued: August 21, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Amarillo, TX, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On October 5, 2015 appellant filed a timely appeal from a July 24, 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.

ISSUE

The issue is whether appellant has more than six percent permanent impairment of the right and left upper extremity, for which he previously received a schedule award.

[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.*

FACTUAL HISTORY

On October 6, 2010 appellant then a 41-year-old sales and service associate and distribution clerk, filed an occupational disease claim (Form CA-2), alleging that he developed shoulder and arm pain, and tingling in both hands, as a result of repetitively picking up packages, accepting packages from customers, signing receipts, clearing carries, counting money, and working on a keyboard. He first became aware of his condition and realized that it was causally related to his employment on July 2, 2010. OWCP accepted appellant's claim for bilateral medial epicondylitis and bilateral lateral epicondylitis. Appellant stopped work on October 4, 2010.[3]

Appellant was treated by Dr. Michael E. Hebrard, a Board-certified physiatrist, from October 20, 2010 to June 27, 2011, for neck, back, shoulder, and elbow problems. Dr. Hebrard diagnosed chronic sprain of the shoulder and neck, thoracic region; medial and lateral epicondylitis; and bilateral lateral epicondylitis all of which are chronic repetitive strain injuries. He noted that appellant had not worked since October 2010. Dr. Hebrard opined that appellant was at maximum medical improvement.

Appellant saw Dr. Charan K. Singh, a Board-certified neurologist, on August 10 and September 13, 2011, for pain in the hands, arms, wrists, and elbows due to performing repetitive duties at work including throwing parcels, casing mail, writing notices, and computer use. Dr. Singh noted that a magnetic resonance imaging (MRI) scan of the cervical spine dated December 22, 2010 revealed a two-millimeter central bulge at C5-6 with mild anterior indentation of the cord without central or foraminal stenosis. She diagnosed chronic neck, upper thoracic and bilateral shoulder strain, and bilateral carpal tunnel syndrome. Dr. Singh opined that appellant's symptoms were causally related to the repetitive nature of her work.

On November 30, 2011 Dr. Singh noted that appellant had experienced chronic neck and shoulder pain since 2006. Appellant reported that the pain began while she was working as a window clerk clearing parcels, writing parcels, typing international custom forms, and counting money. The pain increased and remained constant. An electromyogram (EMG) performed on November 11, 2011 revealed bilateral patchy median and ulnar sensory neuropathy. Dr. Singh noted findings of bilateral elbow and wrist pain, left base of thumb pain, decreased strength in the proximal and distal upper extremities, with intact sensation and reflexes. She diagnosed bilateral elbow, wrist, arm, forearm, and hand pain beginning July 2, 2010 and bilateral patchy median and ulnar sensory neuropathy. Dr. Singh opined that appellant's pain started when she was working at the window typing forms, writing parcels and notices, clearing carriers, and counting money. She found appellant totally disabled from work.

On January 30, 2012 appellant filed a claim for a schedule award (Form CA-7).

On February 8, 2012 OWCP requested that appellant obtain a medical report from his treating physician evaluating the extent of his permanent impairment under the sixth edition of

[3] The record indicates that appellant has other accepted claims pertaining to his neck, back, and arms. These claims are not before the Board in the current appeal.

the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*).[4]

Appellant submitted an EMG report dated November 11, 2011, which revealed bilateral patchy, mild median, and ulnar sensory neuropathy. The findings revealed significant right elbow pain, wrist pain, and shoulder and neck pain which appeared to be biomechanical rather than neurological.

On March 26, 2012 OWCP referred appellant to Dr. Aubrey Swartz, a Board-certified orthopedic surgeon, for a second opinion evaluation of appellant's permanent impairment under the A.M.A., *Guides*. In a May 8, 2012 report, Dr. Swartz noted a history of appellant's July 2010 injury. Pinwheel testing of the arms revealed feeling in the proximal forearm only. Appellant had pain with light tapping of the medial epicondyles radiating to the distal humerus and a negative Tinel's sign and Phalen's test. He had collapsing weakness with thumb abductor strength testing of both thumbs as well as tenderness to light fingertip touch in the lateral and medial epicondyles of both elbows. Dr. Swartz calculated impairment for the bilateral upper extremities and referenced Table 15-33, page 474 of the A.M.A., *Guides*, using the range of motion (ROM) method for rating impairment.

With regard to the elbows, Dr. Swartz noted extension was zero degrees for zero impairment, flexion measured 115 degrees for three percent impairment, pronation measured 90 degrees for zero impairment, and supination measured 90 degrees for zero impairment. He determined appellant had three percent permanent impairment of the bilateral upper extremities for loss of ROM. Dr. Swartz noted with regard to right and left lateral epicondylitis, appellant qualified for a grade modifier 1, pursuant to Table 15-35 of the A.M.A., *Guides*. He noted that the grade modifier for functional history, for a mild condition, was 1 for both lateral elbows. Dr. Swartz calculated three percent upper extremity permanent impairment for the right and left lateral epicondylitis of the elbows. He further noted that appellant had mild bilateral ulnar neuropathy to qualify for cubital tunnel syndrome in both medial elbows. Dr. Swartz referenced the nerve entrapment section of the A.M.A., *Guides*, and, for clinical studies, he noted that appellant was a grade modifier 1. For functional history, appellant had a grade modifier 1 and for physical examination he had a grade modifier zero. Dr. Swartz calculated bilateral cubital tunnel impairment by adding the grade modifier for functional history and the grade modifier for clinical studies and divided that figure by 3 to obtain .67 or 1. He noted a *Quick*DASH score of 42 was borderline between grade modifier 1 and grade modifier 2. Dr. Swartz noted grade modifier 2 was reasonable and opined that appellant had two percent upper extremity permanent impairment for bilateral cubital tunnel syndrome. He opined that appellant had eight percent bilateral arm permanent impairment pursuant to the A.M.A., *Guides*.

In a December 6, 2012 report, an OWCP medical adviser reviewed Dr. Swartz's impairment finding. She opined that appellant had six percent permanent impairment of each arm pursuant to the A.M.A., *Guides*. The medical adviser noted that Dr. Swartz provided impairment for the bilateral elbow based on both ROM and neuropathy. She advised that the A.M.A., *Guides* provide that the best method of rating impairment is the method that yields the

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

highest impairment percentage and that rating by multiple methods will lead to duplication of impairment. The medical adviser indicated that the diagnosis-based impairment (DBI) method was preferred. She noted impairment due to bilateral medial and lateral epicondylitis, pursuant to Table 15-4, page 399, appellant was a default class 1, for one percent. The medical adviser found the grade modifier for Clinical Studies (GMCS) inapplicable. The grade modifier for Physical Examination (GMPE) was 1, pursuant to Table 15-8, page 408. The grade modifier for Functional History (GMFH) was 2, pursuant to Table 15-7, page 408. Applying the net adjustment formula of (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), the medical adviser found a net adjustment of +1, grade D, for an impairment rating of two percent for the bilateral upper extremities. For entrapment neuropathy, bilateral cubital tunnel syndrome was evaluated pursuant to Table 15-23, page 449 of the A.M.A., *Guides*. The medical adviser noted impairment for clinical studies was a grade modifier 1. The grade modifier for functional history was 2 and the grade modifier for physical examination was 1. The medical adviser noted the average grade modifier was 1.33 which is rounded down to 1 for bilateral upper extremity impairment of two percent.[5] He noted functional impairment was assessed as severe, 3, which would increase impairment to three percent.

With regard to entrapment neuropathy, bilateral carpal tunnel syndrome was evaluated pursuant to Table 15-23, page 449 of the A.M.A., *Guides*. The medical adviser noted impairment for clinical studies was a grade modifier 1. The grade modifier for functional history was 1 and the grade modifier for physical examination was zero. The medical adviser noted the average grade modifier was .67 which was rounded up to 1, and therefore bilateral upper extremity impairment of two percent. He noted functional impairment was assessed as mild, 1, for impairment of two percent. The medical adviser noted that in evaluating entrapment neuropathy, the second impairment rating, bilateral carpal tunnel syndrome, was taken at half value or one percent bilateral upper extremity impairment, pursuant to the A.M.A., *Guides*, page 448, Multiple Simultaneous Neuropathies. The medical adviser opined that appellant had six percent permanent impairment of each arm.

In a decision dated May 17, 2013, OWCP granted appellant a schedule award for six percent permanent impairment for both the right and left arms. The period of the award was from April 23, 2012 to January 10, 2013.

On August 25, 2014 appellant filed a claim for an increased schedule award (Form CA-7). On September 8, 2014 OWCP requested that he obtain a medical report from his treating physician evaluating the extent of his permanent impairment under the A.M.A., *Guides*.

In a decision dated December 3, 2014, OWCP denied appellant's claim for an increased schedule award because the medical evidence of record did not support an increase in the impairment rating already granted.

[5] The policy of OWCP is to round the calculated percentage of impairment to the nearest whole point. Results should be rounded down for figures less than .5 and up for .5 and over. *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.b (January 2010); *Carolyn E. Sellers*, 50 ECAB 393, 394 (1999).

On December 10, 2014 appellant requested an oral hearing which was held on May 20, 2015. He submitted a report from Dr. Hebrard dated September 17, 2014. Dr. Hebrard diagnosed bilateral epicondylitis and bilateral lateral epicondylitis. He opined that appellant reached maximum medical improvement on September 17, 2014. Dr. Hebrard noted that, based upon his evaluation, the differential diagnosis was bilateral medial and lateral epicondylitis. He noted tenderness to palpation of the medial and lateral epicondyle regions, weakness with wrist extension, flexion and grip consistent with the diagnoses and weakness with grasping, pinching, pulling and lifting. Dr. Hebrard noted that pursuant to the A.M.A., *Guides*, Table 15-4, page 399, elbow regional grid, appellant was a class 1 for epicondylitis, lateral or medial. He noted grade modifiers for physical examination of 1 pursuant to the A.M.A., *Guides*, Table 15-8, page 406. Dr. Hebrard noted the grade modifier for functional history was 2 pursuant to the A.M.A., *Guides*, Table 15-7, page 406. He applied the net adjustment formula and found a net adjustment of +1, class D, for an impairment rating of two percent for the bilateral arms for the medial and lateral epicondyle regions.

In a decision dated July 24, 2015, an OWCP hearing representative denied appellant's claim for an increased schedule award. She noted that the report from Dr. Hebrard did not establish that appellant had greater than the six percent permanent impairment previously awarded for each arm.

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.[6] The Secretary of Labor has vested the authority to implement the FECA program with the Director of the Office of Workers' Compensation Programs.[7] 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.[8] 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.[9]

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.

[6] 5 U.S.C. § 8149.

[7] *See* 20 C.F.R. §§ 1.1-1.4.

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

[9] 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).[10] 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.[11]

ANALYSIS

The issue on appeal is whether appellant has more than six percent permanent impairment of the right and left upper extremity for which he previously received a schedule award.

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 had been followed regarding the proper use of the DBI or ROM methodology when assessing the extent of permanent impairment for schedule award purposes.[12] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[13] In *T.H.*, the Board concluded that OWCP physicians were 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 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 found that OWCP could no longer ensure consistent results and equal justice under the law for all claimants.[14]

In order to ensure a consistent result and equal justice under the law for cases involving upper extremity impairment, the Board will set aside the July 24, 2015 decision. Utilizing a consistent method for calculating permanent impairment for upper extremities applied uniformly, and after 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.

CONCLUSION

The Board finds this case not in posture for decision.

[10] *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).

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

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

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

[14] *Supra* note 12.

ORDER

IT IS HEREBY ORDERED THAT the July 24, 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: August 21, 2017
Washington, DC

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

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board