United States Department of Labor
Employees' Compensation Appeals Board

R.C., Appellant	)	
and	)	**Docket No. 16-0424**
	)	**Issued: February 17, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Orangeburg, SC, 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 January 4, 2016 appellant, through counsel, filed a timely appeal from an August 5, 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 sustained more than seven percent permanent impairment of her right upper extremity, for which she previously received a schedule award.

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[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 September 2, 2008 appellant, then a 49-year-old rural carrier, filed an occupational disease claim (Form CA-2) alleging that she sustained carpal tunnel syndrome due to years of repetitive motions with unnatural sitting and body positions. She became aware of her condition and its relationship to her employment on September 1, 2007. In an accompanying statement, appellant also asserted that her job duties aggravated her arm and shoulder conditions. She stopped work on September 10, 2008.

This case has previously been before the Board. By decision dated August 5, 2011, the Board affirmed OWCP's August 23, 2010 decision that appellant had not met her burden of proof to establish an occupational disease in the performance of duty.[3] The facts and circumstances of the case as set forth in the Board's prior decision and order are incorporated herein by reference. Following additional case development, on May 30, 2013, OWCP accepted appellant's claim for the conditions of: cervical strain, right shoulder strain, thoracic strain, right shoulder rotator cuff tear, medial and lateral epicondylitis of the right elbow, right cubital tunnel syndrome and radial tunnel syndrome, right wrist tendinitis and carpal tunnel syndrome, and lumbosacral strain, and paid appropriate benefits.

On August 20, 2013 appellant filed a claim for compensation Form CA-7 requesting schedule award compensation benefits.

In a July 25, 2013 evaluation, Dr. John W. Ellis, a family practitioner, indicated that he was familiar with the job duties of a rural carrier and listed appellant's job duties as well as her medical course since the early 2000s. He noted that she had undergone arthroscopic surgery on January 28, 2008 for right shoulder rotator cuff repair and impingement and right carpal tunnel release March 16, 2009. Dr. Ellis provided examination findings and his review of the medical record. He diagnosed the following conditions as due to appellant's employment: muscle tendon unit strains of the neck, right shoulder and thoracic spine; right brachial plexus impingement; internal derangement, traumatic arthritis, and rotator cuff tear of the right shoulder; medial and lateral epicondylitis of the right elbow with cubital tunnel syndrome and ulnar nerve impingement; medial and lateral epicondylitis of the right elbow with radial tunnel syndrome, asymptomatic; tendinitis of the right wrist with carpal tunnel syndrome; muscle tendon unit strains of the back and right iliolumbar sacroiliac ligaments; and right lumbosacral plexus impingement.

Dr. Ellis opined that appellant had reached maximum medical improvement (MMI) on July 25, 2013, but advised that future surgery might be needed. Utilizing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[4] (hereinafter A.M.A., *Guides*), and citing to tables and figures, he calculated 19 percent permanent impairment of the right upper extremity and 2 percent permanent impairment of the right lower extremity. The 19 percent permanent impairment of the right upper extremity consisted of 10 percent diagnosis-based impairment (DBI) and 10 percent peripheral nerve impairments. The

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[3] Docket No. 10-2342 (issued August 5, 2011).

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

two percent total impairment of the right lower extremity was due to sciatic nerve impairment. Dr. Ellis also attached his worksheet forms explaining his rating.

In an August 23, 2013 report, an OWCP medical adviser reviewed Dr. Ellis' July 25, 2013 report and indicated that many of the items Dr. Ellis considered for impairment were either conditions not accepted by OWCP or not substantiated by objective findings. Utilizing Dr. Ellis' examination findings and the sixth edition of the A.M.A., *Guides*, the medical adviser opined that appellant had a total right upper extremity impairment of six percent and provided his calculation of permanent impairment for the right shoulder and right carpal tunnel syndrome.

Based on the deficiencies noted by OWCP's medical adviser, OWCP referred appellant to Dr. James Bethea, a Board-certified orthopedic surgeon, for a second opinion impairment rating. In an October 10, 2013 report, Dr. Bethea reviewed the statement of accepted facts, the evidence of record, and presented examination findings. An impression of January 28, 2008 right shoulder arthroscopy with open rotator cuff repair and open subacromial depression and status post March 16, 2009 right carpal tunnel release was provided. Dr. Bethea opined that appellant had reached MMI, on July 25, 2013. Under the sixth edition of the A.M.A., *Guides*, he opined that she had a seven percent permanent impairment of the right upper extremity. Under Table 15-5, page 403, Dr. Bethea opined that appellant had class 1 full thickness tear rotator cuff or three percent default impairment. Under Table 15-7 through Table 15-9, he assigned the following grade modifiers: Clinical Studies (GMCS) were nonapplicable, grade modifier 2 for Functional History (GMFH), and grade 2 for Physical Examination (GMPH) and provided an explanation for the assignment of the grade modifiers. A net adjustment of 2 was found under the net adjustment formula, (GMFH - Class of Diagnosis (CDX)) (2-1) + (GMPE - CDX) (2-1) + (GMCS - CDX) (N/A), which moved the final grade from C to E or five percent permanent impairment.

For appellant's carpal tunnel condition, Dr. Bethea found two percent permanent impairment. Under Table 15-23, page 449, he assigned test findings for grade modifier 1, history for grade modifier 2, and physical findings for grade modifier 1. The grade modifiers totaled 4, with an average of 1.33. Therefore, the grade 1 was selected, which had a default upper extremity impairment value of two percent. The *Quick*DASH score was 64, which indicated a moderate functional scale. Dr. Bethea indicated that he selected grade modifier 1 with a default value of two percent. Under the Combined Values Chart on page 604, he found five percent right shoulder impairment and two percent right carpal tunnel impairment equaled a total of seven percent permanent impairment.

On October 25, 2013 an OWCP medical adviser reviewed Dr. Bethea's October 10, 2013 report and found it through and objective. He further opined that Dr. Bethea correctly utilized the sixth edition of the A.M.A., *Guides* and agreed with his impairment calculations for a seven percent total permanent impairment of right upper extremity.

By decision dated October 23, 2013, OWCP granted appellant a schedule award for seven percent permanent impairment of the right arm. The award ran 21.84 weeks from July 25 to December 24, 2013.

On November 7, 2013 OWCP received counsel's November 6, 2013 request for a telephonic hearing before an OWCP hearing representative. The hearing was held on May 8, 2014. No additional evidence was received.

By decision dated July 23, 2014, an OWCP hearing representative affirmed OWCP's October 28, 2013 decision finding no evidence that OWCP's medical adviser had erred in his application of the A.M.A., *Guides*.

On January 20, 2015 OWCP received counsel's January 8, 2015 request for reconsideration based on a new report from Dr. Ellis.

In an updated December 18, 2014 report, Dr. Ellis provided a history of the injury, a review of the medical records, and his examination findings. He opined that appellant's diagnosed conditions of neck sprain, sprain of acromioclavicular (AC), sprain of rotator cuff, carpal tunnel syndrome, sprain of back, thoracic region, other tenosynovitis of hand and wrist, lesion of ulnar nerve, lesion of radial nerve, sprain of lumbar joint ligament, right elbow lateral and medial epicondylitis, right lumbosacral plexus and sciatic nerve impingement, left shoulder tendinitis and left wrist tendinitis were causally related to appellant's work. Dr. Ellis opined that she reached MMI as of October 10, 2013 the date of Dr. Bethea's examination. He opined that appellant had 13 percent combined permanent impairment of the right upper extremity based on the DBI rating method of surgical repair rotator cuff tear, subacromial decompression with AC joint impingement in the shoulder and right peripheral nerve impairments of carpal tunnel syndrome and cubital tunnel syndrome. Dr. Ellis' impairment calculations and impairment worksheets were provided.

In an August 4, 2015 report, an OWCP medical adviser reviewed Dr. Ellis' December 18, 2014 report and found that there was no new or pertinent evidence to support additional impairment to the right arm. He noted that the only applicable diagnoses for impairment were right carpal tunnel syndrome and right rotator cuff tear, and Dr. Ellis provided no new evidence to support an additional right arm schedule award greater than seven percent previously awarded.

By decision dated August 5, 2015, OWCP denied modification of its July 23, 2014 decision.

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 FECA program with the Director of the Office of Workers' Compensation Programs.[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

[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).

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.

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 sustained more than seven percent permanent impairment of her right upper extremity, for which she 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 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

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

[8] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6a (February 2013); Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[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).

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 August 5, 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.

CONCLUSION

The Board finds this case not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the August 5, 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: February 17, 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

[12] *Supra* note 10.