

On appeal counsel contends there is an unresolved conflict in the medical opinion evidence.

FACTUAL HISTORY

On June 7, 2008 appellant, then a 58-year-old letter carrier, filed a traumatic injury claim (Form CA-1) alleging that on June 7, 2008 she injured her left leg and wrist when she fell on cracked pavement. OWCP accepted the claim for left closed distal radius fracture, abrasion of trunk without infection, abrasion of right elbow without infection, and left knee contusion, which was subsequently expanded to include left upper limb reflex sympathetic dystrophy.

On June 5, 2014 appellant filed a claim for a schedule award (Form CA-7). In support of her claim, she submitted a March 4, 2014 impairment rating by Dr. David Weiss, a Board-certified osteopathic physician.

In the March 4, 2014 report, Dr. Weiss provided a history of appellant's injury, reviewed prior medical reports and objective tests, and provided findings on physical examination. In an attached undated *QuickDASH* (QD) worksheet, rating the disabilities of the left arm, shoulder and hand, provided score of 36 percent. Dr. Weiss used appellant's postoperative history, examination findings, diagnostic studies, and QD scores to process an impairment rating of the left upper extremity using the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).³ According to the Wrist Regional Diagnostic Grid, Table 15-3, he identified the left wrist fracture as class 1 with a default value of three percent.⁴ Using the QD score of 36 percent, Functional History (GMFH) equated to a grade modifier of 1;⁵ and Physical Examination (GMPE) a grade modifier of 2.⁶ Dr. Weiss indicated that Clinical Studies (GMCS) were not applicable.

Applying the net adjustment formula at section 15-3, pages 409 and 411 of the A.M.A., *Guides*,⁷ Dr. Weiss subtracted 1, the numerical value of the class, from the numerical value of the grade modifier for each component (functional history and physical examination, as clinical studies was not applicable) and then added those values, resulting in a net adjustment of 1 ((1-1) + (2-1)).⁸ Using the net adjustment value of 1 moved the grade within the class 1 position to the

³ A.M.A., *Guides* (2009).

⁴ *Id.* at 396.

⁵ *Id.* at 406, Table 15-7.

⁶ *Id.* at 408, Table 15-8.

⁷ *Id.* at 409, 411.

⁸ *Id.*

right from 3 to 4 or a grade D.⁹ This resulted in four percent left upper extremity impairment for the left wrist fracture.¹⁰

For appellant's mild sensory deficit of the left median nerve above the mid forearm, Dr. Weiss indicated that appellant fell within class 1 of the Peripheral Nerve Impairment Diagnostic Grid at five percent using Table 15-21.¹¹ Using the QD score of 36 percent, functional history equated to a grade modifier of 1¹² and a grade modifier of 4 for symptomatic clinical studies.¹³ As physical examination was not applicable, the net modifier adjustment formula was 3 which moved the rating from 1 to the right for 10 percent left median peripheral nerve impairment.¹⁴ Thus, Dr. Weiss concluded that appellant had a total seven percent permanent impairment of her left upper extremity for sensory deficit under the sixth edition of the A.M.A., *Guides*.

For appellant's moderate motor strength deficit of the left median nerve (grip), Dr. Weiss indicated that appellant fell within class 2 of the Peripheral Nerve Impairment Diagnostic Grid at 17 percent using Table 15-21.¹⁵ He found a grade modifier of 1 for functional history due to mild problems and a grade modifier of 4 for symptomatic clinical studies. As physical examination was not applicable, the net modifier adjustment formula was a net adjustment of 1 which moved the rating to the right to class D for 20 percent moderate left median nerve motor strength impairment.¹⁶ Thus, Dr. Weiss concluded that appellant had a total 31 percent permanent impairment of her left upper extremity under the sixth edition of the A.M.A., *Guides*. He found that appellant had reached maximum medical improvement (MMI) on March 4, 2014.

On September 8, 2014 OWCP routed Dr. Weiss' report, a statement of accepted facts (SOAF), and the case file to an OWCP district medical adviser, Dr. Morley Slutsky, Board-certified in occupational medicine. In a September 9, 2014 report, the medical adviser stated that appellant had reached MMI of the upper left extremity on March 14, 2014. Dr. Slutsky noted that complex regional pain syndrome (CRPS) was an accepted condition; however, the objective evidence was insufficient to warrant a schedule award. The medical adviser provided calculations regarding the wrist fracture using Table 15-3 of the Wrist Regional Diagnostic Grid sixth edition of the A.M.A., *Guides*.¹⁷ He identified the left wrist fracture as class 1, assigned a

⁹ *Id.* at 396, Table 15-3.

¹⁰ *Supra* note 3.

¹¹ A.M.A., *Guides* 437, Table 15-21

¹² *Id.* at 406, Table 15-7.

¹³ *Id.* at 411, Table 15-9.

¹⁴ *Supra* note 11.

¹⁵ *Id.*

¹⁶ *Supra* note 11.

¹⁷ *Supra* note 4.

grade modifier of 2 for functional history;¹⁸ a grade modifier of 1 for physical examination due to left wrist range of motion¹⁹ and a grade modifier of 2 for x-rays under clinical studies.²⁰ Applying the net adjustment formula at section 15-3, pages 409 and 411 of the A.M.A., *Guides*,²¹ resulted in a net adjustment of 2 $((2-1) + (1-1) + (2-1))$.²² Using net adjustment formula, the value of 2 moved the grade within the class 1 position to the right from 3 to 5, or grade E.²³ This resulted in five percent left upper extremity impairment. Thus, the medical adviser concluded that appellant had five percent permanent impairment of the left upper extremity.

By decision dated April 29, 2015, OWCP granted appellant a schedule award for five percent permanent impairment of the left upper extremity.

In a letter dated May 5, 2015, counsel requested an oral hearing before an OWCP hearing representative, which was held on September 24, 2015.

In an October 9, 2015 report, Dr. Weiss reviewed the medical adviser's September 9, 2015 report and noted his disagreement with the medical adviser regarding an impairment rating for CRPS. He related that CRPS was an accepted condition. Dr. Weiss explained that there were two types of CRPS. In CRPS Type 1, neither the initiating causative factor nor the symptoms involve a specific peripheral nerve structure; therefore, the impairment is rated under Table 15-26 CRPS Type I. In CRPS Type II, a specific sensory of mixed nerve structure is involved; therefore, the rating is based on Table 15-21, peripheral nerve impingement upper extremity impairments.²⁴ Dr. Weiss concluded that appellant had been diagnosed with CRPS Type II and that Table 15-21, page 437 was appropriate to be used in calculating her impairment rating. He reiterated that appellant was entitled to 31 percent left upper extremity permanent impairment rating based on his prior impairment rating.

By decision dated December 9, 2015, an OWCP hearing representative set aside the April 29, 2015 decision and remanded the case for the medical adviser to review Dr. Weiss' October 9, 2015 report.

On January 12, 2016 OWCP routed the October 9, 2015 report, a SOAF, and the case file to a different medical adviser, Dr. Taisha S. Williams, a physiatrist. In a January 23, 2016 report, Dr. Williams reviewed Dr. Weiss' October 9, 2015 report and noted her disagreement with the diagnosis of CRPS. She related that appellant's condition did not meet the criteria for

¹⁸ *Id.* at 406, Table 15-7.

¹⁹ *Id.* at 409, Table 15-8.

²⁰ *Id.* at 419, Table 15-9.

²¹ *Id.* at 409, 411

²² *Id.*

²³ *Id.* at 396, Table 15-3.

²⁴ *Id.* at 451.

CRPS under Table 15-24, page 453. Dr. Williams reported that the impairment rating remained unchanged from Dr. Slutsky's prior finding of five percent left upper extremity permanent impairment. She found the date of MMI to be March 4, 2014.

By decision dated February 17, 2016, OWCP denied appellant's claim for an additional impairment.

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.²⁵ 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.²⁶ 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.²⁷

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).²⁸ 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.²⁹

²⁵ See 20 C.F.R. §§ 1.1-1.4.

²⁶ For a complete loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1).

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

²⁸ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (February 2013).

²⁹ *Isidoro Rivera*, 12 ECAB 348 (1961).

The A.M.A., *Guides* notes that when impairment results strictly from a peripheral nerve lesion, no other rating method is applied to this section (15.4 Peripheral Nerve Impairment) to avoid duplication or unwarranted increase in the impairment estimation.³⁰

Section 8123(a) provides that, if there is 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.³¹ When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of FECA, to resolve the conflict in the medical evidence.³²

ANALYSIS

OWCP accepted the claim for left closed distal radial fracture, abrasion of trunk without infection, abrasion of right elbow without infection, left knee contusion, and left upper limb reflex sympathetic dystrophy. By decision dated April 29, 2015, it granted appellant a schedule award for five percent permanent left upper extremity impairment based upon the medical adviser's opinion for fracture of the left wrist. OWCP denied her request for an additional schedule award in a February 17, 2016 decision. The issue on appeal is whether appellant has established more than five percent permanent impairment of the left upper extremity, for which she previously received a schedule award.

The Board finds that this case is not in posture for decision due to a conflict in medical opinion between Dr. Weiss and the medical advisers as to whether appellant had ratable CRPS, thereby warranting an increased schedule award.

In a September 9, 2014 report, Dr. Slutsky, the medical adviser, advised that based on the A.M.A., *Guides* appellant had five percent impairment of the left upper extremity. Using Table 15-3 of the Wrist Regional Diagnostic Grid sixth edition of the A.M.A., *Guides*, left wrist fracture, appellant had a class 1, grade E, five percent permanent impairment. Dr. Williams, a second medical adviser, concurred with Dr. Slutsky's assessment.

The medical advisers also noted that, while CRPS was an accepted condition, they disagreed with Dr. Weiss' finding that appellant's condition was ratable. The medical advisers related that pursuant to Table 15-24 on page 453 appellant's CRPS was not ratable.

By contrast, in reports dated March 4, 2014 and October 9, 2015, Dr. Weiss opined that appellant had a total 31 percent impairment of the left upper extremity. Specifically regarding CRPS, he calculated appellant's permanent impairment for mild sensory deficit of the median

³⁰ A.M.A., *Guides* at 423. The Board notes that the A.M.A., *Guides* provide that peripheral nerve impairment may be combined with DBIs at the upper extremity as long as the DBI does not encompass the nerve impairment. *Id.* at 419.

³¹ 5 U.S.C. § 8123(a). See *S.R.*, Docket No. 09-2332 (issued August 16, 2010); *Y.A.*, 59 ECAB 701 (2008); *Darlene R. Kennedy*, 57 ECAB 414 (2006).

³² *A.R.*, Docket No. 09-1566 (issued June 2, 2010); *M.S.*, 58 ECAB 328 (2007); *Bryan O. Crane*, 56 ECAB 713 (2005).

nerve using Table 15-21, Peripheral Nerve Impairment Diagnostic Grid. Dr. Weiss explained that, pursuant to the A.M.A., *Guides*, there were two types of CRPS. As appellant had CRPS Type II, his rating was based on Table 15-21 for peripheral nerve impairments. Dr. Weiss rated appellant's permanent impairment for mild sensory deficit and moderate strength deficit of the median nerve using Table 15-21.³³

The Board finds there is an unresolved conflict in the medical opinion evidence concerning the extent of permanent impairment arising from appellant's CRPS. Dr. Weiss determined that appellant was entitled to an impairment rating for CRPS under Table 15-21 of the A.M.A., *Guides* while the medical advisers determined appellant did not have a ratable CRPS, under Table 15-24, and therefore appellant was not entitled to an impairment rating for this condition. Therefore, in order to resolve the conflict in the medical opinions, the case will be remanded to OWCP for referral of the case record, including a SOAF and appellant, to an impartial medical specialist for a determination, in accordance with the relevant standards of the A.M.A., *Guides*, as to whether appellant and is entitled to an impairment rating for the CRPS.

The Board further finds that the case is not in posture for decision with regard to the extent and degree of left upper extremity impairment regarding appellant's left wrist fracture. Dr. Weiss utilized the diagnosis-based impairment (DBI) methodology to conclude that appellant's left wrist fracture contributed to his overall 31 percent permanent impairment of the left upper extremity by four percent. In also utilizing the DBI methodology, the medical advisers concluded that the left wrist fracture was the only ratable impairment resulting in a total five percent permanent impairment of the left upper extremity.

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 the range of motion (ROM) methodology when assessing the extent of permanent impairment for schedule award purposes.³⁴ The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.³⁵ In *T.H.*, the Board concluded that OWCP's 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 cited to language in the first printing or the second printing when justifying use of either ROM or DBI methodology. Because OWCP's own physicians were 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.³⁶

³³ *Id.* at 438.

³⁴ *T.H.*, Docket No. 14-0943 (issued November 25, 2016).

³⁵ *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

³⁶ *Supra* note 34.

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 February 17, 2016 decision. Utilizing 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 a left upper extremity schedule award.

CONCLUSION

The Board finds this case not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the February 17, 2016 decision of the Office of Workers' Compensation Programs is set aside and this case is remanded for further proceedings consistent with this opinion, to be followed by a *de novo* decision.

Issued: July 7, 2017
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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