

**United States Department of Labor
Employees' Compensation Appeals Board**

S.W., Appellant)

and)

DEPARTMENT OF JUSTICE, BUREAU OF)
PRISONS, FEDERAL CORRECTIONAL)
COMPLEX, Beaumont, TX, Employer)

**Docket No. 17-0801
Issued: July 14, 2017**

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
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On February 28, 2017 appellant filed a timely appeal from a January 24, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act¹ (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 met her burden of proof to establish more than six percent permanent impairment of the right upper extremity, for which she previously received a schedule award.

On appeal appellant disagrees with the number of weeks paid and the degree and nature of her permanent impairment.

¹ 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On August 28, 2012 appellant, then a 35-year-old correctional officer, filed a traumatic injury claim (Form CA-1) alleging that she injured her right hand that day when it was caught in a closing van door. She did not stop work and began treatment with Dr. Oscar J. Currie, a Board-certified orthopedic surgeon. OWCP accepted closed fracture of other metacarpal bones, right, on October 12, 2012. In reports dated October 12, 2012, Dr. Currie noted examination findings of no tenderness about the index finger with full range of motion of fist and fingers with minor decreased strength. He diagnosed healed index finger metacarpal base fracture. Dr. Currie advised that appellant was at maximum medical improvement (MMI) and could return to full duty.

Dr. Juan E. Davila, an attending Board-certified physiatrist and associate of Dr. Currie, performed upper extremity electrodiagnostic studies on April 11, 2013. He advised that the studies were within normal limits. A second set of electrodiagnostic studies done by Dr. Davila on November 7, 2014 were also normal. On December 18, 2014 Dr. Currie acknowledged the two negative sets of studies, noted appellant's complaint of right hand pain and numbness, and advised that carpal tunnel steroid injections gave her significant pain relief. He diagnosed right carpal tunnel syndrome. In an April 13, 2015 report, Dr. Michael A. Monmouth, a Board-certified orthopedic surgeon, also diagnosed right carpal tunnel syndrome.

On May 7, 2015 OWCP accepted right carpal tunnel syndrome. Dr. Currie performed right carpal tunnel release on July 15, 2015. He followed appellant postoperatively. On May 24, 2016 Dr. Currie released appellant to full duty and advised that she was at MMI. He indicated that he would see her on an as-needed basis.

On November 14, 2016 appellant filed a claim for a schedule award (Form CA-7). She submitted a September 1, 2016 report in which Dr. Frank L. Barnes, Board-certified in orthopedic surgery, noted the history of injury and appellant's medical and surgical history. Dr. Barnes advised that examination of the right wrist demonstrated a well-healed scar, moderately limited range of motion, 4/5 strength, and no swelling, discoloration, instability, crepitation, or deformity. Sensory testing to light touch caused an aching feeling throughout the entire hand and fingers. Motion of the right fingers showed marked limitation.

Dr. Barnes diagnosed fracture of right second metacarpal bone. He advised that appellant reached MMI on April 24, 2016 when she was released to full duty by Dr. Currie.² Dr. Barnes reported a *QuickDASH* score of 81.7 for symptoms, and a *QuickDASH* score of 62.5 under the work module. He advised that, in accordance with Table 15-2, Digit Regional Grid, of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),³ appellant had a class 1 impairment with six percent

² There is no report from Dr. Currie dated April 24, 2016. As noted, by report dated October 12, 2012, Dr. Currie advised that appellant was at MMI for the metacarpal fracture and released her to full duty. By report dated May 24, 2016, he noted that appellant was at MMI with regard to her carpal tunnel syndrome. Dr. Currie released appellant to full duty.

³ A.M.A., *Guides* (6th ed. 2009).

default value. Dr. Barnes found no adjustments for clinical studies and functional history, and an adjustment of one for physical examination, finding two percent permanent impairment of the right arm due to metacarpal fracture.

For the diagnosis of contusion of right hand, Dr. Barnes found that under Table 15-3, Wrist Regional Grid, this diagnosis yielded a class 1 impairment with no modifiers for clinical studies and functional history. Dr. Barnes found a modifier of two for physical examination, based on severe loss of wrist motion, which yielded two percent permanent impairment of the right arm due to wrist contusion.

For the diagnosed carpal tunnel syndrome, he found that under Table 15-23, Entrapment/Compression Neuropathy Impairment, with functional history and physical examination severe with definable sensory loss, mild weakness, and no atrophy, she had eight percent right upper extremity permanent impairment due to carpal tunnel syndrome. Dr. Barnes added the three impairment values and concluded that appellant had a total 12 percent right upper extremity permanent impairment.

In a December 27, 2016 report, Dr. Arthur S. Harris, a Board-certified orthopedic surgeon and OWCP medical adviser, noted his review of the record, including Dr. Barnes' report. He advised that, in accordance with Table 15-2, appellant had one percent upper extremity permanent impairment for the metacarpal fracture. For the diagnosed right carpal tunnel syndrome, under Table 15-23, appellant had two percent upper extremity permanent impairment for residual problems of mild carpal tunnel syndrome. OWCP's medical adviser utilized the Combined Values Chart and concluded that appellant had a total three percent right upper extremity permanent impairment.

Appellant's file was also referred to Dr. Todd Fellars, a Board-certified orthopedic surgeon and OWCP medical adviser. In a January 9, 2017 report, Dr. Fellars noted his review of the medical record and the accepted conditions of closed fracture of base of right metacarpal bone and right carpal tunnel syndrome. He indicated that appellant had a normal examination and reached MMI for the finger fracture on October 25, 2012 and, therefore, had no permanent impairment due to this injury. Dr. Fellars indicated that, for carpal tunnel syndrome, under Table 15-23, she had atrophy and a poor functional history, with 4/5 grip strength. He found a class 2 impairment with a modifier of one for functional history which yielded six percent right arm permanent impairment. Dr. Fellars indicated that he disagreed with Dr. Barnes' impairment rating because appellant's current loss of motion was not associated with her index finger fracture or work injury. He further indicated that he did not feel there was evidence of severe carpal tunnel syndrome, finding that based on the information provided appellant had a class 2 impairment. Dr. Fellars concluded that appellant was at MMI for right carpal tunnel syndrome on September 1, 2016.

By decision dated January 24, 2017, appellant was granted a schedule award for six percent right upper extremity permanent impairment, for 14.64 weeks of compensation, to run from September 1 to December 12, 2016.

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.⁴ 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.⁵ 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.⁶

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).⁷ 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.⁸

Under the sixth edition of the A.M.A., *Guides*, entrapment neuropathy, such as carpal tunnel syndrome, is addressed at section 15-4f.⁹ Having established the diagnosis of carpal tunnel syndrome, the next step in the rating process is to consult Table 15-23, entitled *Entrapment/Compression Neuropathy Impairment*.¹⁰ The table provides a series of grade modifiers from zero to four and a range of corresponding upper extremity impairments from zero

⁴ See 20 C.F.R. §§ 1.1-1.4.

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

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

⁷ 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).

⁸ *Isidoro Rivera*, 12 ECAB 348 (1961).

⁹ *Supra* note 3 at 432.

¹⁰ *Id.* at 448-49.

to nine percent. Grade modifiers are assigned based on a combination of factors including test findings, history, and physical findings.¹¹

ANALYSIS

The issue on appeal is whether appellant established more than six percent permanent impairment of the right upper extremity. The accepted conditions in this case are closed fracture of base of other metacarpal bones, right, and carpal tunnel syndrome, right. On January 24, 2017 appellant was granted a schedule award for six percent right arm permanent impairment, based on the opinion of Dr. Fellars, an OWCP medical adviser.

With regard to the diagnosis of carpal tunnel syndrome, the Board finds a conflict in medical evidence has been created. In a September 1, 2016 report, Dr. Barnes, an attending Board-certified orthopedic surgeon, found that under Table 15-23, Entrapment/Compression Neuropathy Impairment, with functional history and physical examination severe, with definable sensory loss, mild weakness, and no atrophy, appellant had eight percent right upper extremity permanent impairment due to carpal tunnel syndrome.

In contrast, Dr. Fellars, OWCP's medical adviser, also a Board-certified orthopedic surgeon, reported on January 9, 2017 that he did not feel appellant had severe carpal tunnel syndrome. He noted atrophy and a poor functional history and 4/5 grip strength. Dr. Fellars advised that, under Table 15-23, appellant had a class 2 impairment with a modifier of one for functional history which yielded six percent right upper extremity impairment. He noted his disagreement with Dr. Barnes' impairment rating because appellant's current loss of motion was not associated with her index finger fracture or work injury.

Table 15-23 provides a series of grade modifiers from zero to four and a range of corresponding upper extremity impairments from zero to nine percent. Grade modifiers are assigned based on a combination of factors including test findings, history, and physical findings. Dr. Barnes and Dr. Fellars disagreed regarding modifiers and the class of impairment.

Thus, this case is not in posture for decision regarding the diagnosed carpal tunnel syndrome because there is a conflict in the medical opinion evidence between Dr. Barnes and Dr. Fellars regarding the degree of appellant's right upper extremity impairment due to carpal tunnel syndrome.¹²

In order to resolve the conflict in the medical opinion evidence regarding appellant's right upper extremity impairment for the diagnosed carpal tunnel syndrome, the case shall be remanded to OWCP for referral of appellant to an impartial medical specialist for an examination and impairment evaluation for this right upper extremity diagnosis.¹³ After this and other

¹¹ Additional grade modifications are permitted using the *QuickDASH* (Disabilities of the Arm, Shoulder, and Hand) functional assessment tool.

¹² *Melvina Jackson*, 38 ECAB 443 (1987).

¹³ See *S.C.*, Docket No. 15-1630 (issued October 23, 2015); 5 U.S.C. § 8123(a) (if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary of Labor shall appoint a third physician who shall make an examination).

development deemed necessary, OWCP shall issue a *de novo* decision regarding appellant's entitlement to schedule award compensation due to the accepted right carpal tunnel syndrome.

As to the diagnosed metacarpal fracture of the right index finger, the Board also finds that the 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 diagnosis-based impairment (DBI) or range of motion (ROM) methodology when assessing the extent of permanent impairment for schedule award purposes.¹⁴ The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.¹⁵ 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 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 have been found to be inconsistent in the application of the A.M.A., *Guides*, the Board finds that OWCP could no longer ensure consistent results and equal justice under the law for all claimants.¹⁶

In order to ensure consistent results and equal justice under the law for cases involving upper extremity impairment, the Board will set aside the January 24, 2017 decision. Following OWCP's use 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 additional right upper extremity schedule award.

CONCLUSION

The Board finds this case not in posture for decision.

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

¹⁵ *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

¹⁶ *Supra* note 14.

ORDER

IT IS HEREBY ORDERED THAT the January 24, 2017 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: July 14, 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