United States Department of Labor
Employees' Compensation Appeals Board

J.V., Appellant	)	
and	)	**Docket No. 17-1766**
	)	**Issued: April 3, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Tampa, FL, 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
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 11, 2017 appellant filed a timely appeal from a June 13, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act (FECA)[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the claim.

ISSUE

The issue is whether appellant has established greater than 37 percent permanent impairment of her left upper extremity and 31 percent permanent impairment of her right upper extremity, for which she previously received schedule awards.

On appeal appellant contends that she was improperly referred for an impartial medical examination. She noted that both her physician and the second opinion physician believed that she had 9 percent permanent impairment to her left upper extremity and 14 percent permanent

[1] 5 U.S.C. § 8101 *et seq.*

impairment of her right upper extremity. Appellant contended that the doctors agreed that she had reached maximum medical improvement.

FACTUAL HISTORY

On February 11, 2009 appellant, then a retired 59-year-old flat sorter machine operator, filed an occupational disease claim (Form CA-2) alleging that she had previously sustained shoulder, back, and neck injuries in the performance of her federal employment duties. During treatment for those conditions, she was diagnosed with bilateral carpal tunnel syndrome. In a separate statement, appellant described in detail her duties with the employing establishment, including coding and sorting mail. The record reflects that she had retired on disability from the employing establishment on July 1, 2008.[2]

On December 28, 2009 OWCP accepted appellant's present claim, assigned File No. xxxxxx992, for bilateral carpal tunnel syndrome. On January 7, 2015 it expanded acceptance of this claim for the additional condition of lesion of the ulnar nerve, right.

Appellant received numerous schedule awards in File No. xxxxxx996. On March 2, 2010 OWCP issued a schedule award for seven percent permanent impairment of the right upper extremity based on impairment to her right shoulder. On April 21, 2011 it issued a schedule award for eight percent impairment of appellant's left upper extremity based on permanent impairment to her left shoulder. On November 7, 2011 OWCP issued a schedule award for an additional 21 percent permanent impairment for appellant's right upper extremity (for a total 28 percent permanent impairment of the right upper extremity) based on her shoulder injuries. On January 22, 2014 it found that appellant had an additional 26 percent permanent impairment of the left upper extremity due to her C5-6 cervical radiculopathy (for a total 34 percent total permanent impairment of the left upper extremity).

On November 27, 2012 OWCP issued a schedule award in the present case for three percent permanent impairment of appellant's left upper extremity and three percent permanent impairment of her right upper extremity, based on her accepted bilateral carpal tunnel syndrome. Appellant's schedule awards then totaled 37 percent permanent impairment of the left upper extremity and 31 percent permanent impairment of the right upper extremity.

On January 20, 2016 appellant filed a claim for an additional schedule award (Form CA-7).

In support thereof, appellant submitted a December 17, 2015 report wherein Dr. Samy F. Bishai, her treating orthopedic surgeon, documented appellant's physical examination and reviewed her diagnostic tests. Dr. Bishai then applied the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3] He

[2] In OWCP File No. xxxxxx996, OWCP accepted appellant's 2005 claim for cervical spondylosis without myelopathy, bilateral shoulder sprain, displacement of the cervical disc, back sprain of the lumbar region, adjustment disorder with depression, and chronic pain syndrome.

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

consulted Table 15-23 on page 449 of the A.M.A., *Guides* to calculate impairment rating for ulnar nerve entrapment to the right elbow. Dr. Bishai determined that appellant had nine percent permanent right upper extremity impairment due to her ulnar nerve entrapment. He then calculated appellant's impairment rating for bilateral carpal tunnel syndrome pursuant to Table 15-23. Dr. Bishai found that appellant had nine percent permanent impairment of each upper extremity impairment due to carpal tunnel syndrome. He noted that, since appellant had an ulnar nerve entrapment on her right side, according to the A.M.A., *Guides*, the value of the carpal tunnel syndrome of 9 percent would be reduced to reflect only 50 percent of that rating. Therefore, instead of the 9 percent permanent impairment for carpal tunnel, appellant was only entitled to 4.5 percent impairment rating which was rounded to 5 percent, to yield an impairment rating for the right upper extremity of 5 percent. To obtain the total impairment rating of the right upper extremity, Dr. Bishai combined the 9 percent upper extremity impairment for the right ulnar nerve entrapment with the 5 percent value for the carpal tunnel syndrome on the right side for a total impairment rating of 14 percent impairment for the right upper extremity. An impairment rating of nine percent for the left upper extremity was recommended due to the carpal tunnel syndrome of the left wrist.

On February 18, 2016 OWCP asked a district medical adviser (DMA) whether appellant was entitled to an additional impairment rating. In a March 6, 2016 response, the DMA indicated that he was unable to provide a reasonable impairment rating as Dr. Bishai's December 17, 2015 report was incomplete. He noted that the sensory examination mentioned decreased sensation, but there were no objective measurements. The DMA indicated that the motor examination also showed weak grip strength, but there was no detailed motor function testing. He further indicated that there was no report regarding atrophy. The DMA noted that a copy of the EMG was needed to give an appropriate modifier for clinical studies. He recommended that OWCP refer appellant for another medical evaluation.

On April 6, 2016 OWCP referred appellant to Dr. Fanourios I. Ferderigos, a Board-certified orthopedic surgeon, for a second opinion evaluation. In a May 4, 2016 report, Dr. Ferderigos diagnosed bilateral carpal tunnel syndrome, ulnar nerve entrapment at the right elbow, radiculopathy of the upper extremities due to cervical spondylosis, chronic lumbago, and subjective complaints of radiculopathy of the lower extremities. He evaluated appellant's ulnar nerve entrapment of the right elbow and her bilateral carpal tunnel syndrome. Dr. Ferderigos explained his rating in detail and concurred with Dr. Bishai that appellant had 14 percent permanent impairment of the right upper extremity and 9 percent permanent impairment of the left upper extremity.

On June 6, 2016 a DMA reviewed the case. In a June 6, 2016 report, he noted appellant's diagnoses of bilateral carpal tunnel syndrome and right ulnar nerve cubital tunnel syndrome. The DMA concluded that appellant's right upper extremity rating was six percent plus three percent (1/2 of rating) which equaled nine percent for carpal tunnel and cubital tunnel syndrome. For the left upper extremity, he found six percent permanent impairment for carpal tunnel syndrome. The DMA noted that, if appellant's previous awards were for different joints, then she would be entitled to a final right upper extremity permanent impairment of 34 percent (28 plus 9) and 38 percent left upper extremity permanent impairment (34 plus 6) pursuant to the Combined Values Chart. He noted that, if part of those previous awards were for carpal tunnel

and cubital tunnel syndrome, then the current ratings should be added or subtracted from those previous ratings, whichever was appropriate.

On August 18, 2016 OWCP referred appellant for an impartial medical examination with Dr. Robert Elkins, a Board-certified orthopedic surgeon. It noted that the referral was needed as the second opinion examiner and OWCP's DMA had differing opinions as to the percentage of impairment to the left and right upper extremities. In a September 20, 2016 report, Dr. Elkins reviewed appellant's medical history and the results of her physical examination. He noted appellant's diagnoses as carpal tunnel syndrome with electrodiagnostic evidence, right and left hands; cubital tunnel syndrome, right elbow, with positive electrodiagnostic evidence; prior shoulder surgery on the right; and degenerative arthritic changes at multiple levels in the neck. Dr. Elkins then evaluated appellant's impairment rating under the A.M.A., *Guides*. Using Table 15-23, he found grade modifiers for these findings of 2, for functional history of 2, and for physical findings of 2, and a functional scale grade 2 modifier. Dr. Elkins determined that this resulted in an average of 2, giving appellant a rating of 5 percent upper extremity permanent impairment for the carpal tunnel syndrome on the left. He also noted that appellant had five percent upper extremity impairment for carpal tunnel syndrome on the right, but in addition had an ulnar nerve cubital tunnel syndrome with a grade 2 modifier for test findings, a grade 1 modifier for history, normal physical findings, and grade 1 and grade 2 functional scale. Using the history, physical and functional scales gave appellant a modifier of 5, with a functional average of 2. For the ulnar nerve entrapment, appellant had an average eight percent upper extremity impairment and using the lower value for no atrophy and somewhat intermittent symptoms, he gave her a final rating of seven percent. Because of the reduction rule listed on page 448 of the A.M.A., *Guides* under multiple simultaneous neuropathies, the larger impairment was divided in half which would indicate 3.5 percent impairment rating for the ulnar nerve and 5 percent impairment rating for the wrist indicating 8.5 percent rating, rounded up to 9 percent right upper extremity permanent impairment rating and 5 percent left upper extremity permanent impairment rating.

In a December 5, 2016 report, a DMA determined that appellant had seven percent permanent impairment of her right upper extremity. With regard to the left upper extremity, he concluded that appellant had five percent permanent impairment of her left upper extremity.

In response to a December 9, 2016 query by OWCP, Dr. Elkins wrote an addendum on December 11, 2016, wherein he noted that OWCP's DMA was using grade modifier of 1 *versus* the grade modifier of 2. He indicated that most of the physicians believed that appellant had grade 2 modifiers and some grade 3 modifiers, both of OWCP DMA's believed that appellant had a grade modifier of 1. Dr. Elkins contended that this was also true of cubital tunnel syndrome. He explained that he believed his group of modifiers ranging from four to six percent was more accurate based on the data provided and using Table 15-23. Dr. Elkins opined that based on the clinical examination and the fact that appellant seemed honest and legitimate without any evidence of symptom magnification or pain accentuation, he believed that the records and the electrodiagnostic studies justified the original given percentages.

In a February 16, 2017 report, OWCP's DMA indicated that the record reflected prior schedule awards in the amount of 37 percent for the left upper extremity and 31 percent of the right upper extremity. He noted that a physician authorized 3 percent for right upper extremity

and 3 percent for left upper extremity based on nerve entrapment in his report of April 11, 2012 and that therefore the 34 percent of the left upper extremity and 28 percent of the right upper extremity are nonoverlapping with nerve entrapment impairment. The DMA reiterated that he questioned Dr. Elkins calculations due to his use of averaging. He concluded that he was unable to accept Dr. Elkins calculation of impairment based on his deviation from the methodology of the A.M.A., *Guides.*

In a May 2, 2017 letter, OWCP noted that Dr. Elkins had determined nine percent permanent impairment of the right upper extremity due to ulnar nerve cubital tunnel syndrome and carpal tunnel, and five percent permanent impairment of the left upper extremity due to carpal tunnel. It asked Dr. Elkins to consider appellant's prior schedule awards and to determine if appellant had an impairment of greater than 37 percent to her left upper extremity and 31 percent of her right upper extremity. In a June 3, 2017 addendum, Dr. Elkins reviewed appellant's prior awards. He noted that appellant had received prior schedule awards totaling 37 percent impairment of the left arm and 31 percent impairment of the right arm. Dr. Elkins noted that these awards were as follows: 7 percent impairment to the right arm issued on March 2, 2010 for arthroscopic decompression of the right shoulder; 8 percent impairment of the left arm issued on April 21, 2011 based on surgery to the left shoulder; 21 percent additional impairment to the right arm on November 7, 2011 for the Mumford procedure; 3 percent additional impairment to the left arm issued on November 27, 2012 for carpal tunnel median; an additional 3 percent impairment to the right arm issued on November 27, 2012 for carpal tunnel nerve, and an additional 26 percent impairment to the left arm on January 22, 2014 based on C5 sensory and moderate motor deficient. In response to a query from OWCP, Dr. Elkins indicated that, after reviewing appellant's prior ratings, she did not have a greater permanent impairment to her upper extremities than 37 percent to the right arm and 31 percent to the left arm. He noted that he agreed with the prior calculations.

In a decision dated June 13, 2017, OWCP determined that the medical evidence of record did not support an increase in the permanent impairment already compensated and, therefore, the requirements had not been met for an additional schedule award. It noted that this determination was based on the opinion of the impartial medical examiner, Dr. Elkins.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss of or loss of use of scheduled members or functions of the body.[4] However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform stands applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[5]

[4] *Supra* note 1.

[5] *K.H.*, Docket No. 09-0341 (issued December 30, 2011). For decisions issued after May 1, 2009, the sixth edition will be applied. *B.M.*, Docket No. 09-2231 (issued May 14, 2010).

A claimant may seek an increased schedule award if the evidence establishes that he or she sustained an increased impairment at a later date causally related to his or her employment injury.[6]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[7] Under the sixth edition, the evaluator identifies the impairment CDX, which is hen adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[8]

Section 8123(a) provides that, if there is a 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.[9] The implementing regulations state that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[10] In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[11]

ANALYSIS

The Board finds that this case is not in posture for decision.

Dr. Bishai, appellant's treating physician, and Dr. Ferderigos, the second opinion physician, both found that appellant was entitled to a permanent impairment rating of 9 percent for the left upper extremity due to carpal tunnel syndrome of the left wrist, and 14 percent permanent impairment rating of the right upper extremity based on carpal tunnel syndrome and right ulnar nerve impairment. The DMA who evaluated these reports on June 6, 2016, however, found that Dr. Bishai's report provided incomplete physical examination and diagnostic findings. He therefore opined that appellant had six percent permanent impairment of the left upper extremity due to carpal tunnel syndrome, and nine percent permanent impairment of the right upper extremity for carpal tunnel and cubital tunnel syndrome.

[6] *Linda T. Brown*, 51 ECAB 115, 116 (1999); *Paul R. Reedy*, 45 ECAB 488, 490 (1994).

[7] A.M.A., *Guides* (6th ed. 2009), page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): *A Contemporary Model of Disablement.*

[8] *Id.* at 494-531.

[9] *R.C.*, Docket No. 12-0437 (issued October 23, 2012).

[10] 20 C.F.R. § 10.321.

[11] *F.C.*, Docket No. 14-0560 (issued November 12, 2015).

Appellant correctly asserts that OWCP improperly treated Dr. Elkins as an impartial medical examiner. In order to create a conflict in medical opinion, the conflict must exist between an employee's physician and the medical opinion of either a second opinion physician or an OWCP DMA.[12] OWCP referred appellant to Dr. Elkins as a result of a conflict between the DMA and the second opinion physician, who are both Federal Government physicians. As neither of these physicians was claimant's physician, the conflict was insufficient to warrant referral to an impartial medical examiner. However, the opinion of Dr. Elkins can be properly considered as a second opinion physician.[13]

Dr. Elkins initially determined that appellant had nine percent permanent impairment of her right upper extremity due to ulnar nerve entrapment and carpal tunnel syndrome, and five percent left upper extremity impairment for carpal tunnel syndrome. On May 2, 2017 OWCP asked that Dr. Elkins clarify whether these specific ratings were in addition to appellant's prior schedule awards, which he correctly noted totaled 37 percent for permanent impairment of appellant's left arm and 31 percent permanent impairment rating of her right arm.

Dr. Elkins reviewed appellant's prior schedule awards and opined that appellant did not have a greater impairment to her upper extremities than 37 percent permanent impairment of the left upper extremity and 31 percent permanent impairment of the right upper extremity.

The Board finds however that Dr. Elkins did not provide sufficient medical rationale to clarify whether appellant would be in receipt of duplicative awards. In this regard the Board notes that appellant had only received bilateral three percent permanent impairment awards for her carpal tunnel syndrome under this claim. Appellant had otherwise previously received 28 percent permanent impairment award for her right shoulder, as well as 34 percent permanent impairment award for impairment of her left shoulder as well as left arm impairment due to C5-6 cervical radiculopathy under OWCP File No. xxxxxx996. Dr. Elkins did not explain how his own rating of nine percent permanent impairment of the right upper extremity and five percent permanent impairment of the left upper extremity would be duplicative of her prior awards.

FECA[14] and its regulations provide for the reduction of compensation for subsequent injury to the same scheduled member. Specifically, benefits payable under section 8107(c) shall be reduced by the period of compensation paid or payable under the schedule for an earlier injury if: (1) compensation in both cases is for impairment of the same member or function or different parts of the same member or function; and (2) the latter impairment in whole or in part would duplicate the compensation payable for the preexisting impairment.[15] The Board has held that OWCP must adequately explain how the latter impairment duplicated the compensation the claimant previously received under a separate file number.[16]

[12] 20 C.F.R. § 321.

[13] *See Y.S.*, Docket No. 15-1949 (issued April 11, 2016).

[14] *Supra* note 1.

[15] *Id.* at § 8108; 20 C.F.R. § 10.404(d). *See also R.B.*, Docket No. 09-1786 (issued July 1, 2010).

[16] *T.S.*, Docket No. 09-1308 (issued December 22, 2009).

The Board finds that Dr. Elkins did not explain with appropriate rationale how his permanent impairment rating would duplicate appellant's prior awards. Furthermore, while OWCP's DMA questioned whether Dr. Elkins had properly "averaged" appellant's grade modifiers in rating her permanent impairment, OWCP did not request that he clarify this aspect of his rating.

On remand OWCP shall have Dr. Elkins explain, with rationale, why he "averaged" appellant's grade modifiers and whether his rating was duplicative of appellant's earlier award. If he is unable to provide this information, it shall refer appellant for another second opinion evaluation. After such further development as necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated June 13, 2017 is set aside and this case is remanded for further proceedings consistent with this opinion.

Issued: April 3, 2018
Washington, DC

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

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

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