



## ISSUE

The issue is whether appellant has met his burden of proof to establish more than seven percent permanent impairment of each upper extremity, for which he previously received a schedule award.

## FACTUAL HISTORY

On May 5, 1992 appellant, then a 30-year-old mail handler, filed a traumatic injury claim (Form CA-1) alleging that he sustained injury to his upper extremities at work on that date.<sup>3</sup> He indicated that he felt a tingling sensation in both hands while dumping mail flats into a sorting machine. Appellant did not stop work, but began working in a limited-duty position without wage loss.

The findings of November 11, 1993 electromyogram (EMG) and nerve conduction velocity (NCV) testing of appellant's upper extremities contained an impression of abnormal study consistent with bilateral carpal tunnel syndrome (right worse than left) without denervation. There was no evidence of any radiculopathy or myopathy.

OWCP accepted appellant's traumatic injury claim for bilateral carpal tunnel syndrome.

Appellant stopped work on April 12, 1996 and, on the same date, Dr. John McPhilemy, an attending Board-certified orthopedic surgeon, performed right carpal tunnel release surgery. On May 16, 1996 Dr. McPhilemy performed left carpal tunnel release surgery. The procedures were approved by OWCP.<sup>4</sup>

Appellant returned to light-duty work on July 15, 1996 and to full-duty work on July 23, 1996.

On October 10, 2000 appellant filed an occupational disease claim (Form CA-2) alleging that he sustained injury to his upper extremities due to performing his work duties, including lifting mail skids, pushing/pulling mail containers, and operating a forklift truck and tow motor. He indicated that he first became aware of his claimed condition on May 1, 2000 and first realized its relation to his federal employment on May 15, 2000.<sup>5</sup>

In a December 7, 2000 report, Dr. Scott M. Weaner, an attending Board-certified neurologist, indicated that December 7, 2000 EMG and NCV testing of appellant's upper extremities revealed mild bilateral carpal tunnel syndrome, but no evidence of radiculopathy.

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<sup>3</sup> OWCP assigned the claim File No. xxxxxx398.

<sup>4</sup> Appellant received disability compensation for his time off work due to these surgeries.

<sup>5</sup> OWCP assigned the claim File No. xxxxxx243. Appellant indicated on the claim form that he had been off work on sick leave since June 12, 2000 due to "personal reasons."

OWCP accepted appellant's occupational disease claim for bilateral carpal tunnel syndrome.

OWCP administratively combined OWCP File Nos. xxxxxx398 and xxxxxx243, with OWCP File No. xxxxxx398 designated as the master file.

Appellant stopped work on April 9, 2002 and has not returned. On April 9, 2002 Dr. Thomas K. Bills, an attending Board-certified orthopedic surgeon, performed repeat right carpal tunnel release surgery. On May 14, 2002 Dr. Bills performed repeat left carpal tunnel release surgery. Both procedures were approved by OWCP.<sup>6</sup>

The findings of September 13, 2002 EMG and NCV testing of appellant's left upper extremity contained an impression of left carpal tunnel syndrome (with lesion mild compared to older study) and evidence of left C7-8 chronic mild radiculopathy. An October 28, 2002 magnetic resonance imaging (MRI) scan of appellant's cervical spine showed right C3-4 and C5-6 disc protrusions with mild spinal stenosis, and very small central C4-5 disc protrusion without significant spinal stenosis.

In a March 26, 2003 report, Dr. Bills indicated that he examined appellant on that date at which time he complained of left-sided cervical radiculopathy symptoms. He noted that appellant should remain off work.

In October 2003, OWCP referred appellant for a second opinion examination to Dr. Saeid Alemo, a Board-certified neurosurgeon. It asked Dr. Alemo to provide an opinion regarding whether appellant had cervical radiculopathy and, if so, to indicate whether it was related to his employment. OWCP also requested that Dr. Alemo provide an opinion regarding whether appellant had residuals of his accepted bilateral carpal tunnel syndrome.

In a November 5, 2003 report, Dr. Alemo provided a history of appellant's upper extremity condition since 1992 and reported the findings of the physical examination he conducted on November 5, 2003. He opined that appellant did not have a cervical radiculopathy given that the October 28, 2002 MRI scan did not show a herniated disc that would support the left C7-8 radiculopathy seen on the September 13, 2002 EMG and NCV test results. Dr. Alemo also found that appellant still had residuals of bilateral carpal tunnel syndrome.

On April 17, 2006 Dr. Bills performed another repeat right carpal tunnel release surgery which was approved by OWCP.

In December 2008, OWCP referred appellant for a second opinion examination with Dr. David I. Rubinfeld, a Board-certified orthopedic surgeon, and requested that he provide an opinion regarding whether appellant had residuals of his employment-related condition.

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<sup>6</sup> OWCP paid appellant disability compensation on the daily rolls beginning June 1, 2002 and on the periodic rolls beginning January 26, 2003. The record contains a May 13, 2002 document showing that appellant had a weekly pay rate of \$755.11, a figure that included his weekly salary as well as night differential and Sunday premium pay.

In a January 22, 2009 report, Dr. Rubinfeld discussed appellant's history of upper extremity problems and reported findings of his January 19, 2009 physical examination. He diagnosed status post right hand surgery (times three), status post left hand surgery (times two), and possible cervical radiculopathy.<sup>7</sup> Dr. Rubinfeld opined that ongoing findings of bilateral median neuropathies showed that appellant was partially disabled due to these conditions.

In several reports dated between January and March 2009, Dr. Bills opined that appellant had employment-related bilateral carpal tunnel syndrome and cervical radiculopathy. He recommended that appellant remain off work while consideration was given to whether he required additional surgery.

In June 2009, OWCP determined that there was a conflict in the medical opinion evidence between Dr. Rubinfeld and Dr. Bills regarding the nature of appellant's employment-related conditions and the extent of his disability. It referred appellant to Dr. James P. Taitsman, a Board-certified orthopedic surgeon, for an impartial medical examination and opinion on this matter.

In a June 29, 2009 report, Dr. Taitsman detailed appellant's factual and medical history, including an extensive discussion of his diagnostic test results, and reported findings of the physical examination he conducted on that date. He advised that appellant continued to have disability due to his bilateral carpal tunnel syndrome despite undergoing multiple surgeries. Dr. Taitsman opined that appellant's cervical symptoms with cervical radiculopathy/possible neuropathy were not related to a work injury, but rather were related to his underlying degenerative disease. He noted that this lack of an employment-related cause for appellant's cervical radiculopathy condition was supported by the fact that appellant did not report cervical radicular symptoms until after he stopped work in April 2002.

The findings of August 1, 2011 EMG and NCV testing of appellant's upper extremities contained an impression of evidence of bilateral carpal tunnel syndrome and evidence of C5, C6, and C7 radiculopathies with mixed chronic and acute features.

In February 2014, OWCP referred appellant for a second opinion examination with Dr. Stanley R. Askin, a Board-certified orthopedic surgeon, and requested that he provide an opinion regarding whether appellant had residuals of his employment-related condition.

In a February 28, 2014 report, Dr. Askin reported the findings of the physical examination he conducted on that date and posited that appellant had continuing residuals of his accepted bilateral carpal tunnel syndrome. He found that appellant could perform limited-duty work with restrictions on pushing, pulling, and repetitive arm movements.<sup>8</sup>

In an April 2, 2015 report, Dr. Nicholas Diamond, an attending Board-certified physical medicine and rehabilitation physician, discussed appellant's factual and medical history and reported the findings of the physical examination he conducted on that date. He noted that

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<sup>7</sup> Dr. Rubinfeld also noted, "There is no evidence that a prior condition is present."

<sup>8</sup> OWCP requested that Dr. Askin provide a supplement report to clarify his opinion on appellant's ability to work and, in a March 19, 2014 report, he indicated that he did not anticipate that appellant's work restrictions would be permanent.

appellant presented complaining of neck pain with radicular pain into his upper extremities with numbness/tingling extending into his fingers. Upon physical examination, Dr. Diamond observed paravertebral muscle spasms/tenderness of the cervical spine and positive Travell's trigger points, right greater than left. Appellant had positive Tinel's and Phalen's signs in both upper extremities. Dr. Diamond indicated that Semmes-Weinstein testing revealed diminished sensation in both hands associated with the median, C5, and C7 nerve distributions bilaterally. He then evaluated the permanent impairment of appellant's upper extremities under Table 15-23 on page 449 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).<sup>9</sup> Dr. Diamond concluded that appellant had seven percent permanent impairment in each upper extremity due to carpal tunnel syndrome deficits.<sup>10</sup> He also determined that, under *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July/August 2009) (*The Guides Newsletter*), appellant had three percent permanent impairment of each upper extremity due to moderate sensory deficit associated with the C5 nerve root.<sup>11</sup> Dr. Diamond further found, under *The Guides Newsletter*, that appellant had three percent permanent impairment of each upper extremity due to moderate sensory deficit associated with the C7 nerve root.<sup>12</sup> He added the above-noted 7, 3, and 3 percent permanent impairment ratings to conclude that appellant had 13 percent permanent impairment of each upper extremity.<sup>13</sup>

On September 14, 2015 appellant filed a claim for compensation (Form CA-7) seeking a schedule award due to his accepted employment injury.

On November 3, 2015 OWCP referred appellant's case to Dr. Henry J. Magliato, a Board-certified orthopedic surgeon serving as an OWCP medical adviser. It requested that Dr. Magliato review the evidence of record, including Dr. Diamond's April 2, 2015 report, and provide an opinion regarding appellant's upper extremity permanent impairment under the standards of the sixth edition of the A.M.A., *Guides*.

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<sup>9</sup> A.M.A., *Guides* (6<sup>th</sup> ed. 2009).

<sup>10</sup> Dr. Diamond indicated that, under Table 15-23, appellant had a test findings grade modifier of 3, history grade modifier of 3, and physical examination grade modifier of 3, which equaled a default value of eight percent permanent impairment of each upper extremity. Appellant's *QuickDASH* (Disabilities of the Arm, Shoulder, and Hand) score of 45 (under the functional scale) caused this default value to be adjusted to seven percent permanent impairment of each upper extremity.

<sup>11</sup> Dr. Diamond indicated that, under Proposed Table 1 of *The Guides Newsletter*, the default value for each upper extremity due to moderate sensory deficit associated with the C5 nerve root was two percent. He further determined that, under Table 15-6 and Table 15-8 on pages 406 and 408 of the sixth edition of the A.M.A., *Guides*, appellant had a functional history grade modifier of 1 and a clinical studies grade modifier of 4. Application of the net adjustment formula, on page 411 of the sixth edition, caused the default values for these C5 nerve root deficits to be adjusted to three percent permanent impairment in each upper extremity.

<sup>12</sup> Dr. Diamond provided a calculation for permanent impairment in each upper extremity due to moderate sensory deficit associated with the C7 nerve root which was similar to the calculation he provided for permanent impairment in each upper extremity due to moderate sensory deficit associated with the C5 nerve root.

<sup>13</sup> Dr. Diamond indicated that appellant had 14 percent permanent impairment of his left upper extremity, but this clearly was an inadvertent error given the various figures he provided for the left upper extremity. He noted that appellant reached maximum medical improvement (MMI) on April 2, 2015, the date of his physical examination.

In a November 13, 2015 report, Dr. Magliato provided a history of appellant's accepted employment conditions and advised that he had reviewed Dr. Diamond's April 2, 2015 report. He determined that Dr. Diamond properly applied Table 15-23 on page 449 of the sixth edition of the A.M.A., *Guides* to conclude that appellant had seven percent permanent impairment of his right upper extremity due to right median nerve entrapment at his wrist (related to carpal tunnel syndrome). Dr. Magliato opined that it was improper for Dr. Diamond to include right upper extremity permanent impairment of three percent for moderate sensory deficit associated with the right C5 nerve root and right upper extremity permanent impairment of three percent for moderate sensory deficit associated with the right C7 nerve root because these deficits were already included in the permanent impairment rating he calculated for right median nerve entrapment. Similarly, Dr. Magliato found that Dr. Diamond properly concluded that appellant had seven percent permanent impairment of his left upper extremity due to left median nerve entrapment at his wrist. He also determined that it was improper for Dr. Diamond to include left upper extremity permanent impairment of three percent for moderate sensory deficit associated with the left C5 nerve root and left upper extremity permanent impairment of three percent for moderate sensory deficit associated with the left C7 nerve root because these deficits were already included in the permanent impairment rating he calculated for left median nerve entrapment.<sup>14</sup> Dr. Magliato found that appellant reached MMI on April 2, 2015, the date of Dr. Diamond's examination, and concluded that appellant had seven percent permanent impairment of each upper extremity under the sixth edition of the A.M.A., *Guides*.

By decision dated March 28, 2016, OWCP granted appellant schedule award compensation for seven percent permanent impairment of each upper extremity. The award ran for 43.68 weeks from April 2, 2015 to February 1, 2016. It was paid based on a weekly pay rate of \$743.92 and at the basic compensation rate of 66 2/3 percent of pay rate. OWCP found that the weight of the medical opinion regarding appellant's upper extremity permanent impairment rested with Dr. Magliato's November 13, 2015 opinion.

On April 7, 2016 appellant, through counsel, requested a video hearing with a representative of OWCP's Branch of Hearings and Review.

On April 7, 2016 appellant submitted evidence related to claiming his wife as a dependent.

On May 10, 2016 OWCP made a \$9,126.34 payment to appellant which a payment record characterized as a schedule award compensation adjustment designed to reflect that appellant's March 28, 2016 schedule award should have been paid at the augmented rate (75 percent of pay rate) for claimants with at least one qualifying dependent within the meaning of FECA. The record contains a brief worksheet detailing the calculation of the May 10, 2016 payment.<sup>15</sup>

During the hearing held on July 12, 2016, counsel argued that Dr. Diamond's April 2, 2015 report established that appellant had more than seven percent permanent impairment of each upper

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<sup>14</sup> Dr. Magliato noted that Dr. Diamond only tested sensation in appellant's hands.

<sup>15</sup> The worksheet lists a weekly pay rate of \$738.25.

extremity. Counsel also argued that OWCP paid the March 28, 2016 schedule award based on an improper weekly pay rate of \$743.92 rather than the proper weekly pay rate of \$755.11.

By decision dated September 23, 2016, OWCP's hearing representative affirmed OWCP's March 28, 2016 decision, noting that appellant failed to show that he has more than seven percent permanent impairment of each upper extremity, for which he previously received a schedule award. The hearing representative found that the weight of the medical opinion evidence continued to rest with the November 13, 2015 opinion of Dr. Magliato, OWCP's medical adviser. The hearing representative also found that an error in the weekly pay rate for appellant's schedule award was corrected on May 10, 2016 when appellant received a compensation adjustment payment to reflect that the schedule award compensation should have been paid at the augmented dependency rate (75 percent of pay rate) rather than the basic compensation rate (66 2/3 of pay rate), and should have been based on a weekly pay rate of \$755.11 rather than \$743.92.

### **LEGAL PRECEDENT**

The schedule award provision of FECA<sup>16</sup> and that of its implementing regulation<sup>17</sup> set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. 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 standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.<sup>18</sup> The effective date of the sixth edition of the A.M.A., *Guides* is May 1, 2009.<sup>19</sup>

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.<sup>20</sup> In Table 15-23, grade modifiers levels (ranging from 0 to 4) are described for the categories Test Findings, History, and Physical Findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating value may be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities.<sup>21</sup>

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<sup>16</sup> 5 U.S.C. § 8107.

<sup>17</sup> 20 C.F.R. § 10.404 (1999).

<sup>18</sup> *Id.*

<sup>19</sup> See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

<sup>20</sup> See A.M.A., *Guides* 449, Table 15-23.

<sup>21</sup> A survey completed by a given claimant, known by the name *QuickDASH*, may be used to determine the function scale score. *Id.* at 448-49.

It is well established that, in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included.<sup>22</sup> There is no basis for including subsequently-acquired conditions.<sup>23</sup> When a claimant does not demonstrate any permanent impairment caused by the accepted exposure, the claim is not ripe for consideration of any preexisting impairment.<sup>24</sup> OWCP procedures provide:

“Impairment ratings for schedule awards include those conditions accepted by the OWCP as job related, and any preexisting permanent impairment of the same member or function. If the work-related injury has affected any residual usefulness in whole or in part, a schedule award may be appropriate. There are no provisions for apportionment under the FECA. Rated impairment should reflect the total loss as evaluated for the schedule member at the time of the rating exam[ination].<sup>25</sup>

In some instances, OWCP’s medical adviser’s opinion can constitute the weight of the medical evidence. This occurs in schedule award cases where an opinion on the percentage of permanent impairment and a description of physical findings is on file from an examining physician, but the percentage estimate by this physician is not based on the A.M.A., *Guides*. In this instance, a detailed opinion by OWCP’s medical adviser may constitute the weight of the medical evidence. As long as OWCP’s medical adviser explains his or her opinion, shows values and computation of impairment based on the A.M.A., *Guides*, and considers each of the reported findings of impairment, his or her opinion may constitute the weight. If the attending physician misapplied the A.M.A., *Guides*, no conflict would exist because the attending physician’s report would have diminished probative value and the opinion of OWCP’s medical adviser would constitute the weight of medical opinion.<sup>26</sup>

### ANALYSIS

The Board finds that appellant has not met his burden of proof to establish more than seven percent permanent impairment of each upper extremity, for which he previously received a schedule award.

The Board finds that OWCP’s medical adviser, Dr. Magliato, properly determined in his November 13, 2015 report that appellant had seven percent permanent impairment of each upper extremity under the standards of the sixth edition of the A.M.A., *Guides*. Dr. Magliato correctly determined that, under Table 15-23 on page 449 of the sixth edition, appellant had seven percent

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<sup>22</sup> *D.F.*, 59 ECAB 288 (2007); *Kenneth E. Leone*, 46 ECAB 133 (1994).

<sup>23</sup> *R.G.*, Docket No. 13-0220 (issued May 9, 2013).

<sup>24</sup> *Thomas P. Lavin*, 57 ECAB 353 (2006).

<sup>25</sup> Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.806.5(d) (February 2013).

<sup>26</sup> Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.8j (September 2010); *M.P.*, Docket No. 14-1602 (issued January 13, 2015).

permanent impairment of his right upper extremity due to right median nerve entrapment at his wrist (related to carpal tunnel syndrome). He also found, applying a similar calculation, that appellant had seven percent permanent impairment of his left upper extremity due to left median nerve entrapment at his wrist. In this regard, Dr. Magliato agreed with the April 2, 2015 calculation of Dr. Diamond, an attending physician, regarding the permanent impairment of appellant's upper extremities due to carpal tunnel syndrome deficits. He agreed that, under Table 15-23 on page 449 of the sixth edition, appellant had a test findings grade modifier of 3, history grade modifier of 3, and physical examination grade modifier of 3, which equaled a default value of eight percent permanent impairment of each upper extremity. Appellant's *QuickDASH* score of 45 (under the functional scale) caused this default value to be adjusted to seven percent permanent impairment of each upper extremity.<sup>27</sup> Dr. Magliato further explained that it was improper for Dr. Diamond to include, for each upper extremity, a permanent impairment rating of three percent for moderate sensory deficit associated with the C5 nerve root and a permanent impairment rating of three percent for moderate sensory deficit associated with the C7 nerve root because these deficits were already included in the permanent impairment rating calculated for median nerve entrapment in each upper extremity.

On appeal counsel argues that, for each upper extremity, appellant's schedule award should have included Dr. Diamond's three percent permanent impairment rating for moderate sensory deficit associated with the C5 nerve root and his three percent permanent impairment rating for moderate sensory deficit associated with the C7 nerve root because these impairment ratings were caused by a preexisting cervical condition. As noted above, permanent impairment ratings for schedule awards include those conditions accepted by OWCP as related to the employment, and any preexisting permanent impairment of the same member or function.<sup>28</sup> The Board notes, however, that OWCP's rationale for excluding permanent impairment ratings for deficits associated with the bilateral C5 and C7 nerve roots was not because they were subsequently-acquired conditions, but rather was because Dr. Magliato had determined that the permanent impairment from these deficits were duplicative of the seven percent permanent impairment caused by appellant's bilateral carpal tunnel syndrome, for which he later received schedule award compensation.

On appeal counsel also questions whether the weight of the medical opinion evidence should rest with the opinion of Dr. Magliato given his role as OWCP's medical adviser. However, the opinion of the medical adviser may constitute the weight of the medical opinion evidence in a schedule award case when, as in the instant case, the permanent impairment rating of the attending physician is not entirely based on the A.M.A., *Guides*, but the medical adviser provides a detailed permanent impairment rating derived in accordance with the A.M.A., *Guides*.<sup>29</sup>

The Board thus finds that appellant has not established greater than seven percent permanent impairment of each upper extremity, for which he previously received schedule award

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<sup>27</sup> See A.M.A., *Guides* 449, Table 15-23.

<sup>28</sup> See *supra* notes 22 and 25.

<sup>29</sup> See *supra* note 26.

<sup>29</sup> 5 U.S.C. § 8101(4).

compensation. Appellant may request a schedule award or increased schedule award at any time based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

The Board, however, further finds that the case is not in posture for decision as additional development is required regarding whether appellant received the proper amount of compensation for this permanent impairment. OWCP's hearing representative found in his September 23, 2016 decision that on May 10, 2016 appellant received a \$9,126.34 compensation adjustment payment which corrected the amount of compensation paid to appellant for the March 28, 2016 schedule award. The hearing representative indicated that this adjustment payment was designed to rectify the fact that appellant's schedule award compensation was improperly paid at the basic compensation rate (66 2/3 of pay rate) rather than the augmented dependency rate (75 percent of pay rate) as well as the fact that appellant was paid at the improper weekly pay rate of \$743.92 rather the weekly pay rate of \$755.11.<sup>30</sup> The case record contains an OWCP worksheet which purports to show that appellant was entitled to a \$9,126.34 payment because his schedule award compensation should have been paid at the augmented dependency rate rather than the basic compensation rate.

The Board finds that this adjustment calculation appears to be improper. OWCP used a weekly pay rate of \$738.25 and there is no indication that an adjustment payment was calculated to reflect that appellant had been paid schedule award compensation at the weekly pay rate of \$743.92 rather than the weekly pay rate deemed by OWCP's hearing representative to have been proper for the purposes of paying schedule award compensation, *i.e.*, \$755.11. Therefore, the case should be remanded to OWCP for further development regarding the proper amount of compensation for the March 28, 2016 schedule award. Following this and other further development as deemed necessary, OWCP shall issue a *de novo* decision.

### CONCLUSION

The Board finds that appellant has not met his burden of proof to establish more than seven percent permanent impairment of each upper extremity, for which he previously received schedule award compensation. The Board further finds that additional development is required regarding whether appellant received the proper amount of compensation for this permanent impairment.

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<sup>30</sup> On April 7, 2016 appellant submitted documentation which OWCP accepted as qualifying him for the payment of compensation at the augmented rate (75 percent of pay rate) for claimants with at least one dependent within the meaning of FECA. Appellant sustained a recurrence of disability in mid-2002 and a document from that time shows that he had a weekly pay rate of \$755.11, a figure that included his weekly salary as well as night differential and Sunday premium pay. See 5 U.S.C. § 8101(4) regarding the effect of a recurrence of disability on pay rate, and 5 U.S.C. §§ 8105(a), 8106(a), and 8110(b) regarding the payment of compensation at the augmented rate. See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Determining Pay Rates*, Chapter 2.900.6(b) (March 2011), regarding the inclusion of night differential and Sunday premium pay in pay rate calculations.

**ORDER**

**IT IS HEREBY ORDERED THAT** the September 23, 2016 decision of the Office of Workers' Compensation Programs is affirmed in part and set aside in part. The case is remanded to OWCP for further action consistent with this decision.

Issued: August 7, 2018  
Washington, DC

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

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

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