United States Department of Labor
Employees' Compensation Appeals Board

A.B., Appellant	)	
and	)	**Docket No. 16-0706**
	)	**Issued: February 15, 2018**
DEPARTMENT OF THE AIR FORCE, ILLINOIS AIR NATIONAL GUARD, SCOTT AIR FORCE BASE, IL, 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 February 26, 2016 appellant filed a timely appeal from a December 7, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP).[1] Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of the case.[3]

[1] Appellant submitted a timely request for oral argument pursuant to 20 C.F.R. § 501.5(b). By order dated October 7, 2016, the Board exercised its discretion and denied the request as appellant's arguments on appeal could be adequately addressed in a decision based on a review of the case as submitted on the record. *Order Denying Request for Oral Argument*, Docket No. 16-0706 (issued October 7, 2016).

[2] 5 U.S.C. § 8101 *et seq.*

[3] The record provided the Board includes evidence received after OWCP issued its December 7, 2015 decision. The Board's jurisdiction is limited to the evidence that was in the case record at the time of OWCP's final decision. Therefore, the Board is precluded from reviewing this additional evidence for the first time on appeal. 20 C.F.R. § 501.2(c)(1).

ISSUE

The issue is whether appellant has more than 16.5 percent permanent impairment of his left upper extremity and more than 23 percent permanent impairment to his right upper extremity, for which he previously received schedule awards.

FACTUAL HISTORY

On November 2, 2005 appellant, then a 34-year-old aircraft mechanic, filed an occupational disease claim (Form CA-2) alleging that he developed carpal tunnel syndrome in the performance of duty on or about September 14, 2005. On December 14, 2005 OWCP accepted the claim for bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome, and right lateral epicondylitis.

On February 10, 2006 appellant underwent right carpal tunnel release and right cubital tunnel release. On March 2, 2006 he underwent similar surgical procedures with respect to his left upper extremity. On October 2, 2006 appellant underwent additional right elbow surgery for recurrent right cubital tunnel syndrome. All three surgical procedures were authorized by OWCP and were performed by Dr. Khashayar Dehghan, a Board-certified plastic surgeon.

On January 4, 2007 appellant filed a claim for a schedule award (Form CA-7).

By decision dated July 3, 2007, OWCP granted appellant a schedule award for 16.5 percent permanent impairment of the left upper extremity and 23 percent permanent impairment of the right upper extremity pursuant to the 5th Edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] The award covered a period of 121.68 weeks and ran from April 19, 2007 to August 16, 2009.

On March 28, 2010 appellant filed a claim for an additional schedule award (Form CA-7).

In an October 20, 2011 report, Dr. Michael E. Beatty, a Board-certified plastic surgeon, found that appellant had 46 percent bilateral upper extremity permanent impairment. He advised that he calculated a diagnosis-based impairment (DBI) rating on history, physical examination findings, and clinical studies. Dr. Beatty reported that appellant's disabilities of the arm, shoulder, and hand (DASH) yielded a *Quick*DASH score of 46.

In a May 13, 2013 report, Dr. David H. Garelick, a Board-certified orthopedic surgeon and OWCP medical adviser, found that appellant's accepted conditions did not provide a basis for additional bilateral upper extremity impairment under the sixth edition of the A.M.A., *Guides*[5]. He noted that Dr. Beatty's 46 percent upper extremity impairment was not rendered in conformance with the applicable tables and charts of the A.M.A., *Guides*, and that he did not explain the basis for the rating. Dr. Garelick surmised that Dr. Beatty based his impairment

[4] A.M.A., *Guides* (5th ed. 2001).

[5] *Id.* at (6th ed. 2009).

rating on loss of range of motion (ROM) methodology, rather than the preferred DBI methodology. He further noted that the August 7, 2009 postsurgical electromyography (EMG) results showed normal findings for right/left median and ulnar neuropathy, brachial plexopathy, and cervical plexopathy. Dr. Garelick determined that appellant had eight percent bilateral upper extremity permanent impairment based on multiple entrapment neuropathies (carpal and cubital tunnel syndrome) under Table 15-23, A.M.A., *Guides* 449.

By decision dated July 25, 2013, OWCP denied appellant's claim for an additional schedule award. Based on Dr. Garelick's May 13, 2013 report, it found that the medical evidence of record did not support an increase over the prior award for 16.5 percent permanent impairment of his left upper extremity and 23 percent permanent impairment of his right upper extremity.

On June 5, 2014 OWCP expanded appellant's accepted conditions to include bilateral upper extremity residual paresthesia and bilateral surgically-treated compressive neuropathies involving the median and ulnar nerves. However, it deferred acceptance of thoracic outlet syndrome pending further medical development.[6]

In a December 29, 2014 report, Dr. Jacob Aubuchon, a pain management specialist, advised that appellant was experiencing right shoulder and bilateral arm pain, which symptoms had begun 10 years prior. Appellant's diagnoses included carpal tunnel syndrome, ulnar nerve entrapment, and thoracic outlet syndrome. Dr. Aubuchon also noted that appellant had undergone bilateral carpal tunnel release and bilateral ulnar nerve release surgery in 2006 to 2007. Since his surgeries, appellant's pain had gradually worsened over the past three years. Dr. Aubuchon noted that appellant had continuous, throbbing, shooting, stabbing, aching pain in both arms, which was associated with intermittent numbness in his left and right arms. Appellant rated his pain as 5 on a scale of 1 to 10 and the pain was aggravated with raising his arms.

On May 13, 2015 appellant filed a claim for an additional schedule award (Form CA-7).

In a June 11, 2015 report, Dr. Michael Hellman, an orthopedic surgeon and OWCP medical adviser, determined, using the DBI methodology, that appellant had three percent bilateral upper extremity permanent impairment based on entrapment/compression neuropathies (cubital and carpal tunnel syndromes) pursuant to Table 15-23, A.M.A., *Guides* 449. He also found an additional one percent right upper extremity permanent impairment for lateral epicondylitis under Table 15-4, Elbow Regional Grid, A.M.A., *Guides* 399.

By decision dated June 23, 2015, OWCP denied appellant's claim for an additional schedule award. It found that the medical evidence of record did not support an increase in the impairment already compensated.

On July 16, 2015 appellant requested reconsideration of the June 23, 2015 schedule award decision.

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[6] OWCP ultimately expanded the claim to include thoracic outlet syndrome as an accepted condition.

In a July 5, 2015 report, Dr. Robert H. Thompson, a Board-certified vascular surgeon, diagnosed bilateral, right greater than left, neurogenic thoracic outlet syndrome, which he attributed to appellant's former aircraft mechanic duties.[7] Appellant's reported symptoms included pain primarily in the right shoulder and hand. There was also reported numbness and tingling extending from the neck to the hands, predominantly in the 4th and 5th digits, and a sensation of weakness in both upper extremities. On physical examination Dr. Thompson reported full range of motion of the left neck and upper extremity, including the ability to put the arm overhead. However, range of motion of the right neck and arm was limited, with immediate pain on attempting to lift the arm. Appellant's *Quick*DASH score was 45.5. Dr. Thompson believed that the majority of appellant's then-current symptoms were more directly related to thoracic outlet syndrome, rather than the previously treated peripheral nerve compression syndromes.

In a November 21, 2015 report, Dr. Hellman, OWCP's medical adviser, reiterated the findings and conclusions he presented in his June 11, 2015 report.

By decision dated December 7, 2015, OWCP denied an additional schedule award. It noted that appellant previously received a schedule award for 16 percent permanent impairment of his left upper extremity and 23 percent impairment of his right upper extremity, and the medical evidence did not support an increase in the impairment already compensated.

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.[8] The Secretary of Labor has vested the authority to implement the FECA program with the Director of OWCP.[9] 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.[10] 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.[11]

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

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[7] Appellant retired effective April 2, 2010 after having been found medically disqualified for world-wide duty.

[8] 5 U.S.C. § 8149.

[9] *See* 20 C.F.R. §§ 1.1-1.4.

[10] For a complete loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1). For a complete loss of use of the middle (2nd) finger, an employee shall receive 30 weeks' compensation. *Id.* at § 8107(c)(9).

[11] 20 C.F.R. § 10.404; *see also Ronald R. Kraynak*, 53 ECAB 130 (2001).

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).[12] The Board has approved OWCP's use 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.[13]

ANALYSIS

The issue on appeal is whether appellant established that he has more than 16.5 percent permanent impairment of his left upper extremity and more than 23 percent permanent impairment to his right upper extremity.

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

The Board has previously found that OWCP had 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 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 DMAs 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.[16]

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 December 7, 2015 decision. Utilizing a consistent method for calculating permanent impairment for upper extremities applied uniformly,

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[12] *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).

[13] *Isidoro Rivera*, 12 ECAB 348 (1961).

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

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

[16] *Supra* note 14.

and after 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.[17]

CONCLUSION

The Board finds this case not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the December 7, 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 15, 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

[17] *See* FECA Bulletin No. 17-06 (issued May 8, 2017).