United States Department of Labor
Employees' Compensation Appeals Board

J.F., Appellant	)	
and	)	**Docket No. 18-0598**
	)	**Issued: July 16, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Chicago, IL, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 26, 2018 appellant, through counsel, filed a timely appeal from a December 4, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has met his burden of proof to establish more than 23 percent permanent impairment of his right upper extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On March 2, 2002 appellant, then a 47-year-old letter carrier, filed an occupational disease claim (Form CA-2) alleging that he sustained ulnar nerve compression of his right upper extremity due to the repetitive motion required by his job. He indicated that he first became aware of his claimed condition and its relationship to his federal employment on February 20, 2002. Appellant stopped work on February 20, 2002.

OWCP accepted appellant's claim for right lateral epicondylitis/right elbow inflammatory tendinitis and right ulnar nerve compression. Appellant received disability compensation on the daily rolls beginning March 2, 2002.[3]

On August 15, 2002 Dr. Paul T. Prinz, an attending Board-certified orthopedic surgeon, performed partial right lateral epicondylectomy and debridement/repair of the right extensor carpi radialis brevis tendon. On June 8, 2005 he performed repeat partial right lateral epicondylectomy and repair of the right extensor carpi radialis brevis tendon with removal of fibrotic tissue. Dr. Prinz provided a presurgery diagnosis of right lateral epicondylitis before each surgery. These surgical procedures were approved by OWCP.[4]

On December 8, 2006 appellant filed a claim for compensation (Form CA-7) seeking a schedule award due to his accepted employment-related conditions.

In a January 8, 2007 report, Dr. Prinz reported that his physical examination on that date revealed that appellant's right elbow had full extension, flexion to 130 degrees, pronation to 70 degrees, and supination to 90 degrees. Appellant's grip strength was 63 on the left and 36 on the right. Dr. Prinz indicated that appellant had "43 percent diminished grip strength." He noted that appellant had "43 percent loss of strength in the right upper extremity" and opined that this loss was permanent. In an attached January 8, 2007 permanent impairment worksheet, Dr. Prinz concluded that appellant had 43 percent permanent impairment of his right upper extremity.

In March 2007, OWCP referred appellant's case to Dr. David H. Garelick, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA) for OWCP. It requested that he review the medical evidence of record, including Dr. Prinz' January 8, 2007 report, and provide an opinion regarding appellant's upper extremity permanent impairment under the

[3] OWCP paid appellant disability compensation on the periodic rolls beginning September 3, 2006.

[4] Appellant stopped work for brief periods associated with these two surgeries and he returned to limited-duty work for the employing establishment in each instance. He also stopped work on May 1, 2010 and returned to limited-duty work on August 20, 2012. Appellant received appropriate disability compensation for these work stoppages. He retired from the employing establishment and began receiving Office of Personnel Management benefits effective September 12, 2016.

standards of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[5]

In a March 19, 2007 report, Dr. Garelick applied the standards of the fifth edition of the A.M.A., *Guides* to calculate the permanent impairment of appellant's right upper extremity. He determined that, under Table 16-10 on page 482 and Table 16-15 on page 492, appellant had three percent permanent impairment due to pain in the right musculocutaneous nerve distribution. Under Table 16-31 and Table 16-34 on page 509, appellant had 21 percent permanent impairment due to right grip strength deficits. Dr. Garelick combined these permanent impairment ratings to conclude that appellant had 23 percent permanent impairment of his right upper extremity.

By decision dated September 17, 2007, OWCP granted appellant a schedule award for 23 percent permanent impairment of his right upper extremity. The award ran for 71.76 weeks from November 26, 2006 to April 11, 2008 and was based on the opinion of Dr. Garelick.

On October 31, 2007 appellant requested a telephone hearing with a representative of OWCP's Branch of Hearings and Review. During the hearing held on January 30, 2008, he asserted that he was entitled to an increased schedule award for upper extremity permanent impairment.

By decision dated April 11, 2008, OWCP's hearing representative affirmed OWCP's September 17, 2007 decision. The hearing representative found that appellant failed to establish more than 23 percent permanent impairment of his right upper extremity.

Appellant continued to receive periodic medical treatment from Dr. Prinz for his right upper extremity condition. In an October 6, 2016 note, Dr. Prinz indicated that appellant had reached maximum medical improvement (MMI) with respect to that condition.

In a November 30, 2016 report, Dr. Prinz discussed appellant's factual and medical history with respect to his right upper extremity condition, including his complaints of right lateral epicondylar pain. He indicated that physical examination findings revealed bilateral elbow range of motion (ROM) of 0 to 125 degrees with full pronation and supination bilaterally. Dr. Prinz applied the diagnosis-based impairment (DBI) method of rating permanent impairment and noted that, under Table 15-4 on page 399 of the sixth edition of the A.M.A., *Guides*,[6] appellant's right lateral epicondylitis (class 1) fell under a five percent default value for right upper extremity permanent impairment. He determined that appellant had a grade modifier of 2 for functional history, physical examination, and clinical studies, and determined that application of the net adjustment formula required movement two spaces to the right of the default value on Table 15-4. Therefore, Dr. Prinz concluded that appellant had seven percent permanent impairment of his right upper extremity.[7]

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

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

[7] *Id.* at 399, 405-11.

In December 21, 2016, OWCP referred appellant's case to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a DMA for OWCP. It requested that Dr. Harris review the medical evidence of record, including Dr. Prinz' November 30, 2016 report, and provide an opinion regarding appellant's upper extremity permanent impairment under the standards of the sixth edition of A.M.A., *Guides*.

In a December 23, 2016 report, Dr. Harris opined that, under Table 15-4 of the sixth edition of A.M.A., *Guides*, appellant had seven percent permanent impairment of his right upper extremity based on his right lateral epicondylitis condition (including residual problems status post right elbow surgeries). He found that appellant had reached MMI on November 30, 2016, the date of Dr. Prinz' last examination.

By decision dated June 8, 2017, OWCP determined that appellant failed to meet his burden of proof to establish more than 23 percent permanent impairment of his right upper extremity, for which he previously received a schedule award. It found that the medical evidence of record failed to establish that he had more than 23 percent permanent impairment of his right upper extremity.

On June 16, 2017 appellant requested a telephone hearing with a representative of OWCP's Branch of Hearings and Review. During the hearing held on October 25, 2017, counsel argued that appellant was entitled to an increased schedule award under the standards of the sixth edition of the A.M.A., *Guides*.

By decision dated December 4, 2017, OWCP's hearing representative affirmed OWCP's September 17, 2017 decision. The hearing representative found that the weight of the medical evidence with respect to appellant's upper extremity permanent impairment rested with the opinion of Dr. Harris. Therefore, appellant failed to establish more than 23 percent permanent impairment of his right upper extremity, for which he previously received a schedule award.

LEGAL PRECEDENT

The schedule award provisions of FECA,[8] and its implementing federal regulations,[9] 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[10] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[11]

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

[10] *Id.* at § 10.404(a).

[11] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also id.* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

The sixth edition requires identifying the impairment class for the Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13]

Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides:

> "As the [A.M.A.,] *Guides* caution that if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s)."
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> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify (1) the methodology used by the rating physician (*i.e*., DBI or ROM), and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the* [A.M.A.,] *Guides allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used.*" (Emphasis in original).[14]
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> The Bulletin further advises:
>
> "If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* allow for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE.
>
> "If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* do not allow for the use of ROM for the diagnosis in question, the DMA should independently calculate impairment using the DBI method and clearly explain in the report, citing applicable tables in Chapter 15 of the [A.M.A.,] *Guides*, that ROM is not permitted as an alternative rating method for the diagnosis in question.
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> "If the rating physician provided an assessment using the DBI method and the [A.M.A.,] *Guides* allow for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE.

[12] A.M.A., *Guides* 494-531.

[13] *Id.* at 521.

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

> "If the medical evidence of record is not sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence necessary to complete the rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence."[15]

ANALYSIS

The issue on appeal is whether appellant has met his burden of proof to establish more than 23 percent permanent impairment of his right upper extremity, for which he previously received a schedule award.

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.[16] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[17] 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. The Board therefore found that OWCP should develop a consistent method for calculating permanent impairment for upper extremities, which could be applied uniformly.

As noted above, FECA Bulletin 17-06 provides that, if the rating physician provided an assessment using the DBI method and the A.M.A., *Guides* allows for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE.[18]

The Board therefore finds that this case requires further development of the medical evidence. Since Dr. Prinz provided a rating under the DBI method (based upon appellant's right elbow condition under Table 15-4 on page 399 of the sixth edition of the A.M.A., *Guides*) and Table 15-4 also allows (by asterisk) application of the ROM rating method, Dr. Harris should have independently calculated appellant's impairment using both the ROM and DBI methods under the relevant standards of the sixth edition of the A.M.A., *Guides*, and identified the higher rating for

[15] *Id*.

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

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

[18] *See supra* note 14.

the claims examiner.[19] If the medical evidence of record is not sufficient for Dr. Harris to render a rating using the ROM or DBI method, he should advise as to the medical evidence necessary to complete the rating.[20]

This case will therefore be remanded for application of the new OWCP procedures found in FECA Bulletin 17-06. After such further development of the medical evidence 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 December 4, 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 16, 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

[19] *Id.*

[20] *Id.*