

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

_____)	
G.W., Appellant)	
)	
and)	Docket No. 18-0224
)	Issued: May 9, 2018
U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, Richmond, VA, Employer)	
_____)	

Appearances:
Alan J. Shapiro, Esq., for the appellant¹
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 November 10, 2017 appellant, through counsel, filed a timely appeal from an August 28, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act² (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 established permanent impairment of her bilateral upper extremities for schedule award purposes.

FACTUAL HISTORY

On September 26, 2000 appellant, then a 42-year-old mail handler, filed an occupational disease claim (Form CA-2) alleging that she sustained tendinitis causally related to factors of her federal employment. OWCP accepted the claim for bilateral tendinitis of the elbows and bilateral other synovitis and tenosynovitis. Appellant performed limited-duty employment beginning September 28, 2000.

By decision dated September 15, 2014, OWCP denied appellant's request to expand acceptance of her claim to include carpal tunnel syndrome. It found that the medical evidence of record failed to show that the acceptance of her claim should be expanded to include a consequential injury of carpal tunnel syndrome.

Appellant, on September 14, 2015, requested reconsideration of the September 15, 2014 decision.

On October 31, 2015 Dr. Michael Sheehan, who specializes in family medicine, indicated that appellant had reached maximum medical improvement.

On March 1, 2016 appellant filed a claim for a schedule award (Form CA-7). OWCP, by letter dated March 2, 2016, requested that she submit an impairment evaluation from her attending physician addressing the extent of any permanent impairment due to her work injury in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).³ It advised that it had accepted appellant's claim for other synovitis and tenosynovitis, bilateral. Appellant did not respond within the time allotted.

By decision dated April 13, 2016, OWCP denied appellant's schedule award claim. It noted that she had not responded to its March 2, 2016 request that she submit evidence supporting that she had a permanent impairment warranting a schedule award.

Appellant, through counsel, on April 22, 2016 requested a telephone hearing before an OWCP hearing representative of the April 13, 2016 schedule award denial.

OWCP, by decision dated May 24, 2016, denied modification of its September 15, 2014 decision denying appellant's request to expand the acceptance of her claim to include carpal tunnel syndrome. It found that the medical evidence of record was insufficient to show that she sustained carpal tunnel syndrome due to her accepted work injury.

³ A.M.A., *Guides* (6th ed. 2009).

At the telephone hearing, held on December 7, 2016, counsel related that she was submitting an impairment evaluation from Dr. Robert W. Macht, a surgeon.

In a December 6, 2016 impairment evaluation, Dr. Macht discussed appellant's complaints of pain and weakness of the hands and wrists and triggering of the thumbs bilaterally. He diagnosed bilateral synovitis and tenosynovitis with bilateral thumb triggering and bilateral carpal tunnel syndrome. Referencing the A.M.A., *Guides*, Dr. Macht found two percent impairment of each upper extremity due to triggering of the thumbs according to Table 15-2 on page 392. He further found one percent impairment of each upper extremity due to tendinitis of the wrists using Table 15-3 on page 395 and six percent impairment of each upper extremity due to mild carpal tunnel syndrome using Table 15-23 on page 449. Dr. Macht combined the impairment ratings to find nine percent permanent impairment of each upper extremity.

By decision dated January 25, 2017, OWCP's hearing representative affirmed the April 13, 2016 decision. She found that Dr. Macht did not rate the extent of any permanent impairment due to the accepted condition of elbow tendinitis, but instead provided a rating for the conditions of trigger finger and carpal tunnel syndrome, which were not accepted as employment related.

Dr. Macht, in a report dated February 24, 2017, attributed the diagnosed conditions of bilateral carpal tunnel syndrome and triggering of the thumbs to factors of appellant's federal employment. He further asserted that the conditions were "part of the normal progression of tenosynovitis." Considering only the accepted condition of tenosynovitis of the elbows, wrists, and hands, Dr. Macht found one percent permanent impairment of each upper extremity for wrist tenosynovitis using Table 15-3 on page 395 and one percent impairment of each upper extremity due to elbow tenosynovitis using Table 15-4 on page 398. He combined the impairment ratings to find two percent permanent impairment of each upper extremity.

On April 6, 2017 appellant, through counsel, requested reconsideration of the January 25, 2017 OWCP representative's decision.

An OWCP medical adviser reviewed the evidence on July 7, 2017 and found that it was insufficient to determine the extent of any permanent impairment of the upper extremities as Dr. Macht did not provide range of motion (ROM) measurements of the elbows. He opined that appellant had one percent impairment of each upper extremity due to elbow tendinitis using Table 15-4 of the A.M.A., *Guides*.

OWCP, by letter dated July 27, 2017, requested that appellant submit a supplemental report from Dr. Macht providing three independent measurements of ROM to evaluate the extent of any permanent impairment due to her bilateral elbow tendinitis. It afforded her 30 days to submit the requested evidence. Appellant did not respond within the time allotted.

By decision dated August 28, 2017, OWCP denied modification of its January 25, 2017 decision. It found that appellant failed to submit a supplemental report from her physician containing measurements of each elbow as requested. OWCP thus determined that she had not submitted evidence sufficient to establish a permanent impairment of the upper extremities.

On appeal counsel asserts that OWCP should have used the diagnosis-based impairment (DBI) method to rate her permanent impairment.

LEGAL PRECEDENT

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.⁴ 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.⁵ As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).⁶

The sixth edition requires identifying the impairment Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).⁷ The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

The A.M.A., *Guides* also provide that the ROM impairment method is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other diagnosis-based sections are applicable.⁸ If ROM is used as a stand-alone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are measured and added.⁹ Adjustments for functional history may be made if the evaluator determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.¹⁰

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology *versus* the ROM methodology basis for rating of upper extremity impairments.¹¹ Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides in pertinent part:

“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

⁴ 5 U.S.C. § 8107(c).

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

⁶ *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 (March 2017).

⁷ A.M.A., *Guides* 401-19.

⁸ *Id.* at 461.

⁹ *Id.* at 473.

¹⁰ *Id.* at 474.

¹¹ FECA Bulletin No. 17-06 (issued May 8, 2017).

determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s).

“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 the original.)¹²

The Bulletin further advises:

“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.

“Upon receipt of such a report, and if the impairment evaluation was provided from the claimant’s physician, the CE should write to the claimant advising of the medical evidence necessary to complete the impairment assessment and provide 30 days for submission. Any evidence received in response should then be routed back to the DMA for a final determination. Should no evidence be received within 30 days of the date of the CE’s letter, the CE should proceed with a referral for a second opinion medical evaluation to obtain the medical evidence necessary to complete the rating. After receipt of the second opinion physician’s evaluation, the CE should route that report to the DMA for a final determination.”¹³

ANALYSIS

OWCP accepted that appellant sustained bilateral elbow tendinitis and bilateral tenosynovitis and other synovitis causally related to factors of her federal employment. Dr. Sheehan, her attending physician, found that she had obtained maximum medical improvement on October 31, 2015.

Appellant, on March 1, 2016, filed a claim for a schedule award. In a December 6, 2016 impairment evaluation, Dr. Macht found that she had one percent permanent impairment of each upper extremity due to wrist tendinitis, two percent permanent impairment of each upper extremity due to thumb triggering, and six percent permanent impairment of each upper extremity due to carpal tunnel syndrome. OWCP, however, has not accepted the rated conditions as employment related. Its procedures provide that impairment ratings for schedule awards include those conditions accepted by OWCP as work related, and any preexisting permanent impairment of the

¹² *Id.*

¹³ *Id.*

same member or function.¹⁴ Thus, Dr. Macht's December 6, 2016 impairment evaluation is insufficient to support entitlement to a schedule award.¹⁵

On February 24, 2017 Dr. Macht found that appellant had one percent permanent impairment of each upper extremity due to wrist tenosynovitis using Table 15-3 on page 395 and one percent impairment of each upper extremity due to elbow tenosynovitis using Table 15-4 on page 398. An OWCP medical adviser reviewed Dr. Macht's report on July 7, 2017 and determined that appellant had one percent permanent impairment of each upper extremity due to elbow tendinitis, noting that was the only impairment rating resulting from the accepted condition of bilateral elbow tendinitis. He found that the evidence was insufficient to determine the extent of any permanent impairment of the upper extremities due to reduced motion as Dr. Macht did not provide ROM measurements.

In accordance with FECA Bulletin No. 17-06, OWCP requested that appellant provide a supplemental report from Dr. Macht within 30 days containing ROM measurements in accordance with the procedures set forth in the A.M.A., *Guides*. Appellant did not respond to OWCP's request and, on August 28, 2017, OWCP denied her claim as she had not submitted a report providing ROM measurements of her elbows. As discussed, however, FECA Bulletin No. 17-06 provides that if medical evidence sufficient to make a rating based on ROM is not received within 30 days of the request, OWCP should refer the claimant for a second opinion examination to obtain the necessary medical evidence.¹⁶ The Board will, therefore, remand the case for OWCP to refer appellant for a second opinion examination to obtain the evidence necessary to complete the rating.¹⁷ Additionally, OWCP initially accepted the claim for bilateral elbow tendinitis. However, in its March 2, 2016 schedule award development letter, it indicated that it had it had accepted the claim for bilateral other synovitis and tenosynovitis. On remand, OWCP should clarify the accepted conditions. Following any necessary further development, it shall issue a *de novo* decision with regard to appellant's schedule award claim.

CONCLUSION

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

¹⁴ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(d) (March 2017).

¹⁵ See *F.E.*, Docket No. 17-0584 (issued December 18, 2017).

¹⁶ See *supra* note 10.

¹⁷ See *generally C.J.*, Docket No. 17-1570 (issued February 9, 2018).

ORDER

IT IS HEREBY ORDERED THAT the August 28, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: May 9, 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