United States Department of Labor
Employees' Compensation Appeals Board

E.B., Appellant	)	
	)	
and	)	**Docket No. 19-0530**
	)	**Issued: August 9, 2019**
DEPARTMENT OF THE ARMY, INSTALLATION MANAGEMENT COMMAND, Fort Bragg, NC, 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 January 2, 2019 appellant filed a timely appeal from an August 24, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[2]

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that appellant submitted additional evidence on appeal. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

ISSUE

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

FACTUAL HISTORY

On September 23, 2008 appellant, then a 54-year-old laborer, filed an occupational disease claim (Form CA-2) for a bilateral upper extremity condition due to factors of his federal employment including prolonged "weed-eating" on or about June 14, 2005. After initially denying the claim, OWCP accepted appellant's claim for bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome, and bilateral forearm/elbow sprain -- radial collateral ligament. It also authorized surgery for both upper extremities, which was performed on June 7 and August 9, 2010.

By decision dated March 20, 2012, OWCP granted appellant a schedule award for eight percent permanent impairment of each upper extremity.[3] The award ran for 49.92 weeks for the period January 10 to December 24, 2012.

On March 16, 2017 appellant filed a claim for an increased schedule award (Form CA-7).

In a development letter dated March 31, 2017, OWCP advised appellant of the type of evidence needed to establish his increased schedule award claim. It requested that he provide a medical report from his attending physician, which included an impairment rating utilizing the appropriate portions of the sixth edition of the A.M.A., *Guides*.[4] OWCP afforded appellant 30 days to submit the necessary evidence.

In an April 26, 2017 impairment rating, Dr. Harrison G. Tuttle, a Board-certified orthopedic hand surgeon, determined that appellant had 19 percent permanent impairment of each upper extremity. He conducted an examination of appellant's bilateral upper extremities and noted numbness throughout all fingers and constant pain. Dr. Tuttle reported that the sensation examination was grossly intact to light touch, but was directly diminished throughout all fingers of both hands and he related that an electromyography and nerve conduction velocity (EMG/NCV) study revealed slowing of the sensory conduction and delay of the motor conduction of the left ulnar nerve, nerve conduction velocities showing of the median nerve, and motor and sensory potentials at the wrist. Utilizing Table 15-4, Elbow Regional Grid, Dr. Tuttle assigned class 1 for the diagnosis (CDX) of collateral ligament injury ("frequent instability resulting in functional limitation") and noted a rating of 10 percent permanent impairment, bilaterally. He referenced Table 15-23, Entrapment/Compression Neuropathy, for appellant's bilateral carpal tunnel and cubital tunnel syndromes and determined that he had nine percent impairment bilaterally for

[3] The award was based on a January 27, 2012 report by an OWCP district medical adviser (DMA) who determined that according to Table 15-23, Entrapment/Compression Neuropathy, of the sixth edition of the 2009 edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), appellant had eight percent permanent impairment for his bilateral carpal and cubital tunnel syndromes.

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

multiple nerve (median and ulnar) impairments, which resulted in a combined upper extremity impairment of 19 percent, bilaterally.

On June 16, 2017 OWCP referred appellant's case, along with a purported statement of accepted facts (SOAF) and medical record to Dr. David J. Slutsky, a Board-certified orthopedic surgeon, serving as a DMA. In a June 23, 2017 report, the DMA related that additional information was needed in order to determine whether appellant had increased permanent impairment of the bilateral upper extremities.

On August 8, 2017 OWCP received additional examination notes from Dr. Tuttle dated November 17, 2009 to August 23, 2016 regarding treatment for appellant's worsening bilateral cubital and carpal tunnel symptoms and EMG/NCV study reports dated February 22, 2010 and May 17, 2011.

In an August 22, 2017 letter, Dr. Tuttle related appellant's complaints of continued numbness, pain, and weakness in both hands. Upon examination of appellant's upper extremities, he reported atrophy of the palmar, ulnar, and forearm musculature without erythema. Sensation was intact to light touch, but directly diminished throughout all fingers of both hands. Examination of appellant's wrists revealed full strength and wrist extension. Examination of appellant's elbows showed discomfort with palpation of the lateral aspect of both elbows and stress of the radial collateral ligaments. Dr. Tuttle related that an EMG/NCV study showed symptoms of bilateral mild carpal tunnel syndrome and left cubital tunnel syndrome.

In reports dated September 25 and October 24, 2017, Dr. Slutsky, the DMA, noted that there was no SOAF or medical records presented for his review, including Dr. Tuttle's impairment rating report. He determined that appellant had five percent permanent impairment of each upper extremity for his bilateral carpal and cubital tunnel syndrome. The DMA noted a date of maximum medical improvement (MMI) of March 6, 2012.

By decision dated November 29, 2017, OWCP denied appellant's claim for an increased schedule award because the medical evidence of record failed to establish more than eight percent permanent impairment of each upper extremity, for which he previously received schedule award compensation.

By decision dated April 26, 2018, an OWCP hearing representative set aside the November 29, 2017 OWCP decision and remanded the case because the DMA's permanent impairment ratings were not based on an accurate background.

OWCP subsequently referred appellant's file back to Dr. Slutsky, the DMA, providing the SOAF and relevant medical evidence. In a June 9, 2018 report, the DMA indicated that he had reviewed the SOAF and the medical records provided by OWCP. He noted an MMI date of March 6, 2012. Utilizing the diagnosis-based impairment (DBI) method for rating permanent functional impairment, the DMA determined that appellant had a total of six percent permanent impairment of the right upper extremity. For appellant's right elbow sprain, he utilized Table 15-4, Elbow Regional Grid, and assigned a CDX of 1, grade modifier for functional history (GMFH) of 1 due to diffuse medial elbow pain, grade modifier for physical examination (GMPE) of 1 due to discomfort with palpation of the lateral aspect of the elbow and stress of the radial collateral

ligaments, and grade modifier for clinical studies (GMCS) of 0 due to normal elbow x-ray, which resulted in one percent right upper extremity impairment. For appellant's right carpal tunnel syndrome, the DMA utilized Table 15-23, Entrapment/Compression Neuropathy Impairment, and assigned a CDX of 2, GMFH of 1 due to a *Quick*DASH score of 60, a GMCS of 1 due to conduction delay, and a GMPE of 1 for diminished sensation, which resulted in three percent right upper extremity impairment. For the right cubital tunnel syndrome, he assigned a CDX of 2, a GMFH of 1 due to a *Quick*DASH score of 60, a GMCS of 1 due to prolonged ulnar motor conduction velocities, a GMPE of 1 due to decreased sensation to touch and weak finger abduction, which resulted in three percent right upper extremity impairment. The DMA explained that according to page 450 of the sixth edition of the A.M.A., *Guides*, when there are multiple entrapments, the nerve qualifying for the larger impairment is given the full impairment and combined with 50 percent of the rating of the second nerve. Thus, he calculated that appellant had a total combined right upper extremity permanent impairment of six percent.

With regard to appellant's left upper extremity, Dr. Slutsky, the DMA, again utilized the DBI rating method and assigned a CDX of 1, a GMFH of 1 due to diffuse medial elbow pain, a GMPE of 1 due to discomfort with palpation of the lateral aspect of the elbow and stress of the radial collateral ligaments, but no instability, and a GMCS of zero due to normal x-ray examination, which resulted in one percent left upper extremity impairment. For appellant's left carpal tunnel syndrome, he assigned a CDX of 2, a GMPE of 1 due to decreased sensation, a GMFH of 1 due to a *Quick*DASH score of 60, and a GMCS of 1 due to conduction delay, which resulted in three percent left upper extremity impairment. For appellant's left cubital tunnel syndrome, the DMA assigned a CDX of 2, a GMPE of 1 due to decreased sensation to touch and weak finger abduction, a GMFH of 1 due to a *Quick*DASH score of 61, and a GMCS of 1 due to documented ulnar motor nerve conduction delay, which resulted in three percent left upper extremity impairment. He calculated that appellant had a combined six percent left upper extremity permanent impairment. The DMA noted that peripheral nerve compression could not be rated using the range of motion (ROM) impairment method.

Dr. Slutsky noted his disagreement with Dr. Tuttle's rating of 19 percent permanent impairment and explained how Dr. Tuttle's findings were not based on a proper clinical examination. He further indicated that as appellant was previously granted a schedule award for eight percent permanent impairment of each upper extremity, he was not entitled to an increased schedule award.

By decision dated August 24, 2018, OWCP denied appellant's claim for an increased schedule award. It found that the weight of the medical evidence rested with the June 9, 2018 report of the DMA, who determined that appellant did not have more than eight percent permanent impairment of each upper extremity, for which he previously received schedule award compensation.

LEGAL PRECEDENT

The schedule award provisions of FECA[5] and its implementing regulations[6] 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. FECA, however, does not specify the manner in which the percentage of loss of a member 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 and the Board has concurred in such adoption.[7] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, published in 2009, is used to calculate schedule awards.[8]

In addressing impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated.[9] After a CDX is determined (including identification of a default grade value), the impairment class is then adjusted by GMFH, GMPE, and GMCS.[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and percentage of permanent impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[12]

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).

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404 (1999).

[7] *Id.* at 10.404(a); *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

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

[9] *T.T.*, Docket No. 18-1622 (issued May 14, 2019).

[10] A.M.A., *Guides* 383-492; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[11] *Id.* at 411.

[12] *See supra* note 8 at Chapter 2.808.6 (March 2017). *R.M.*, Docket No. 18-1313 (issued April 11, 2019); *C.K.*, Docket No. 09-2371 (issued August 18, 2010).

"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.*"[13] (Emphasis in the original.)

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 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.[14]

"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."[15]

ANALYSIS

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

As noted above, FECA Bulletin No. 17-06 provides that, if the A.M.A., *Guides* allows for use of ROM for the diagnosis in question, the DMA should independently calculate permanent impairment using both the ROM and DBI methods and identify the higher rating.[16]

In his June 9, 2018 report, Dr. Slutsky, the DMA, evaluated appellant's permanent impairment using the DBI method under Table 15-4 of the A.M.A., *Guides* for bilateral elbow sprains and determined that appellant had one percent permanent impairment of each upper extremity. The Board finds that Table 15-4, Elbow Regional Grid, does allow, by asterisk, that

[13] FECA Bulletin No. 17-06 (issued May 8, 2017); *V.L.*, Docket No. 18-0760 (issued November 13, 2018); *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

[14] *Id.*

[15] *Id.*

[16] *Id*.

elbow sprain/strain be alternatively evaluated by ROM impairment.[17] Dr. Slutsky, however, did not provide an impairment rating utilizing the ROM method nor did he explain why he had not used the ROM methodology in calculating appellant's impairment rating for bilateral elbow sprains. Because the DMA provided a rating for a diagnosed condition which also allowed for a rating based upon loss of ROM, the Board finds that the case must be remanded for the DMA to independently calculate 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 identify the higher rating for the claims examiner.[18] If the medical evidence of record is insufficient for the DMA to render a rating using the ROM method, he should advise as to the medical evidence necessary to complete the rating so that OWCP can undertake further development of the record as may be found necessary.[19]

In addition, appellant was previously granted a schedule award for permanent impairment of each upper extremity due to his bilateral carpal and cubital tunnel syndrome. OWCP determined that Dr. Slutsky's finding of six percent permanent impairment of each upper extremity was insufficient to support an increased schedule award as it was less than the previously awarded eight percent permanent impairment. However, the DMA's June 9, 2018 impairment rating also includes a permanent impairment rating for appellant's accepted bilateral elbow sprain condition. OWCP regulations provide that benefits payable under section 8107(c) shall be reduced by the period of compensation paid 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) OWCP finds that the later impairment in whole or in part would duplicate the compensation payable for the preexisting impairment.[20] The Board finds that OWCP did not adequately explain why appellant's current impairment rating, which includes a rating for his bilateral elbow sprains, would duplicate his previous schedule award compensation for bilateral carpal and cubital tunnel syndromes.[21] The Board has explained that simply comparing the prior percentage of impairment awarded to the current impairment for the same member is not always sufficient.[22] The issue is not whether the current impairment rating is greater than the prior impairment ratings, but whether it duplicates in whole or in part the prior impairment rating.[23]

The case will therefore be remanded for further development consistent with OWCP's procedures set forth in FECA Bulletin No. 17-06. Then, after properly calculating the extent of appellant's current bilateral upper extremity impairment, OWCP should determine whether the

[17] Dr. Tuttle's diagnosis of collateral ligament injury similarly allows for an alternative rating based on loss of range of motion.

[18] *See G.B.*, Docket No. 18-0545 (issued November 19, 2018); *see also B.N.*, Docket No. 17-1923 (issued April 17, 2018).

[19] *Id.*

[20] 20 C.F.R. § 10.404(d).

[21] *See R.B.*, Docket No. 18-1308 (issued January 10, 2019); *see also A.T.*, Docket No. 17-1806 (issued January 12, 2018).

[22] *See T.S.*, Docket No. 16-1406 (issued August 9, 2017).

[23] *Id.*

impairment rating duplicates, in whole or in part, appellant's prior award. Following this and any other development deemed 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 August 24, 2018 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: August 9, 2019
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