United States Department of Labor
Employees' Compensation Appeals Board

P.M., Appellant **and** **DEPARTMENT OF VETERANS AFFAIRS, LOUIS STOKES VETERANS ADMINISTRATION MEDICAL CENTER, Cleveland, OH, Employer**	))))))))))	**Docket No. 18-0826** **Issued: December 6, 2019**

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
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On March 12, 2018 appellant, through counsel, filed a timely appeal from a December 21, 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 her burden of proof to establish more than one percent permanent impairment of the right upper extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On September 21, 2010, appellant then a 47-year-old nurse, filed an occupational disease claim (Form CA-2) alleging that she developed right thumb, wrist, forearm, and elbow pain due to factors of her federal employment including repetitive keyboarding and use of a mouse. She first became aware of her condition on August 20, 2010 and first realized that it was causally related to factors of her federal employment on August 23, 2010. OWCP accepted appellant's claim for right lateral epicondylitis and right radial styloid tenosynovitis. Appellant did not stop work.

Appellant was treated by Dr. Mehrun K. Elyaderani, a Board-certified orthopedist, from September 20, 2010 to August 22, 2011, who diagnosed right de Quervain's tenosynovitis and right lateral epicondylitis. On November 1, 2011 Dr. Elyaderani performed a right de Quervain's release and diagnosed right de Quervain's tenosynovitis. On December 12, 2011 he returned appellant to work full duty. On March 15, 2012 Dr. Elyaderani noted that appellant reached maximum medical improvement (MMI) with regard to de Quervain's disease of the right hand on March 1, 2012.

On March 13, 2012 appellant filed a claim for a schedule award (Form CA-7).

Appellant continued to be treated by Dr. Elyaderani from September 10, 2012 to December 24, 2013, for recurrent lateral epicondylitis. On December 24, 2013 Dr. Elyaderani noted that she reached MMI with respect to her right hand.

On January 27, 2014 appellant filed an additional schedule award claim (Form CA-7).

On January 31, 2014 OWCP requested that appellant obtain a medical report from her treating physician evaluating the extent of her permanent impairment under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*).[3] It afforded her 30 days to submit the requested information. No additional evidence was received.

By decision dated March 19, 2014, OWCP denied appellant's claim for a schedule award finding that the evidence submitted was insufficient to establish that she had sustained permanent impairment to a scheduled member due to her accepted employment injury.

On March 25, 2014 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

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

Appellant submitted a March 5, 2015[4] report from Dr. Catherine Watkins Campbell, Board-certified in occupational medicine and family medicine, who opined that under the A.M.A., *Guides* appellant had six percent permanent impairment for right radial styloid tenosynovitis and two percent permanent impairment for right lateral epicondylitis for a total right upper extremity permanent impairment of eight percent. Dr. Watkins Campbell determined that appellant had reached MMI on December 24, 2013, the date of Dr. Elyaderani's examination.

On July 30, 2014 Dr. Elyaderani noted that appellant continued to have pain in the lateral epicondyle on examination and he diagnosed lateral epicondylitis. He recommended additional physical therapy and follow-up in five to six weeks. Appellant had one week of physical therapy.

By decision dated September 3, 2014, OWCP's hearing representative set aside the March 19, 2014 decision and remanded the case for further medical development. The hearing representative indicated that a new report and impairment rating was received from Dr. Watkins Campbell and should be referred to an OWCP district medical adviser (DMA) for review and calculation of permanent impairment, if any.

On September 9, 2014 OWCP notified appellant that, upon further review of his case file, on July 30, 2014, Dr. Elyaderani had requested resumption of medical care consisting of physical and occupational therapeutic exercises. It noted that it could not develop the claim for a schedule award until MMI was reached. OWCP further indicated that although appellant submitted a report from Dr. Watkins Campbell providing a permanent impairment rating, no additional action would be taken on her request for a schedule award at this time as she was not at MMI.

In a report dated September 15, 2014, Dr. Elyaderani, advised that appellant worked aggressively in physical therapy which improved her right lateral epicondylitis. On December 15, 2015 he opined that she had reached MMI with regard to her right de Quervain's disease.

On December 15, 2015 appellant filed a claim for a schedule award (Form CA-7).

On December 22, 2015 OWCP requested that appellant obtain a medical report from her treating physician evaluating the extent of her permanent impairment pursuant to the A.M.A., *Guides*. It afforded her 30 days to submit the requested information.

On January 5, 2016 Dr. Elyaderani noted that appellant was at MMI with regard to the conditions of de Quervain's tenosynovitis and right lateral epicondylitis. In a return to work slip, dated January 5, 2016, he returned her to work without restrictions on January 6, 2016.

By decision dated April 5, 2016, OWCP denied appellant's claim for a schedule award because the evidence submitted was insufficient to establish permanent impairment to a scheduled member due to the accepted employment injury.

On April 12, 2016 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

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[4] This appears to be a typographical error and should be March 5, 2014.

Appellant submitted a July 15, 2016 report from Dr. Watkins Campbell based on a May 5, 2016 examination in which she diagnosed right radial styloid tenosynovitis and right lateral epicondylitis. Dr. Watkins Campbell indicated that the *Quick*DASH score was 47. The pain disability index was 34/70 and a short-form McGill pain questionnaire indicated that appellant had moderate tendency toward symptom magnification. She noted that, pursuant to the A.M.A., *Guides*, Table 15-3, page 395, wrist regional grid, for the diagnosis wrist sprain/strain, appellant had a class of diagnosis (CDX) of 1 history due to a painful injury, residual symptoms without consistent objective findings for a default impairment of one percent right upper extremity permanent impairment. Dr. Watkins Campbell noted grade modifiers for physical examination (GMPE) of 1 pursuant to the A.M.A., *Guides*, Table 15-8, page 406, observed and palpatory findings. She noted the grade modifier for functional history (GMFH) was 2 for the *Quick*DASH score, pursuant to the A.M.A., *Guides,* Table 15-7, page 406. Dr. Watkins Campbell further noted that there were no clinical studies for the accepted conditions. Applying the net adjustment formula she calculated a net adjustment of +1, class D, for an impairment rating of two percent for the right upper extremity. Dr. Watkins Campbell noted MMI occurred on December 24, 2013. She indicated that the *Quick*DASH score was felt to be equally reflective of both the right wrist and right elbow and was therefore used as a grade modifier in each rating.

Dr. Watkins Campbell reported that pursuant to the A.M.A., *Guides*, Table 15-4, page 399, elbow regional grid, for the diagnosis of elbow muscle/tendon pain appellant was a CDX of 1 for history of painful injury, residual symptoms without consistent objective findings with a default impairment of one percent. She found a GMPE of 1 pursuant to the A.M.A., *Guides*, Table 15-8, page 406, for observed and palpatory findings and a GMFH of 2 pursuant to the A.M.A., *Guides*, Table 15-7, page 406, for the *Quick*DASH score. Dr. Watkins Campbell again noted that there were no clinical studies based on allowed conditions. Applying the net adjustment formula she calculated a net adjustment of +1, class D, for an impairment rating of two percent for the right upper extremity for the lateral epicondyle region. Dr. Watkins Campbell combined the ratings for a total of four percent right upper extremity permanent impairment.

By decision dated September 21, 2016, the hearing representative set aside the April 5, 2016 decision and remanded the case for further medical development. The hearing representative indicated that a new report and impairment rating had been received from Dr. Watkins Campbell and required a referral to a DMA for review and calculation of impairment.

In an October 8, 2016 report, a DMA reviewed Dr. Watkins Campbell's permanent impairment findings. He opined that appellant had one percent permanent impairment of the right upper extremity pursuant to the A.M.A., *Guides*. The DMA indicated that the diagnosis-based impairment (DBI) method was the "preferred method" for performing the impairment rating calculations. He noted permanent impairment due to right radial tenosynovitis, pursuant to Table 15-3, page 395, wrist regional grid, appellant had a CDX of 1 for a default value of one percent permanent impairment. The DMA noted a GMFH of 2, pursuant to Table 15-7, page 408, for the *Quick*DASH score of 47. He noted GMPE of 1, pursuant to Table 15-8, page 408, for mild limitation of range of motion (ROM). The grade modifier for clinical study (GMCS) was zero, pursuant to Table 15-9, page 410, as there were no available clinical study to support the diagnosis. Applying the net adjustment formula of (GMFH - CDX) + (GMPE – CDX) + (GMCS - DCX), the DMA found a net adjustment of zero, grade C, for a permanent impairment rating of one percent for the right upper extremity.

For the right lateral epicondylitis, the DMA noted permanent impairment due to a CDX of 1, pursuant to Table 15-4, page 399, due to a history of painful injury with residual symptoms, but no objective findings, for a default impairment of one percent. He found that the GMFH was inapplicable as it was used for the wrist impairment. The DMA indicated that page 406 of the A.M.A., *Guides* provides that GMFH should be applied only to the single highest DBI. He indicated that the grade modifier for physical examination pursuant to Table 15-8, page 408 was zero, no objective findings as appellant had full ROM. The GMCS, pursuant to Table 15-9, page 410, was zero as there were no clinical studies to confirm the diagnosis. Applying the net adjustment formula the DMA found a net adjustment of -2, grade A, for an impairment rating of zero percent for the right upper extremity. He opined that appellant had one percent impairment of the right upper extremity for right radial tenosynovitis and zero percent impairment of the right upper extremity for right lateral epicondylitis. The DMA noted that the proper date of MMI was July 15, 2016. He indicated that the rating difference between his report and Dr. Watkins Campbell's report was her use of the GMFH which she had used for both DBIs which was inconsistent with the A.M.A., *Guides.*[5]

OWCP forwarded the report of the DMA to Dr. Watkins Campbell and requested that if she disagreed with any part of the report she should provide a narrative report with medical rationale explaining her opinion. No response was received.

By decision dated March 29, 2017, OWCP granted appellant a schedule award for one percent permanent impairment of the right upper extremity. The period of the award was for three weeks from May 5 to 26, 2016.

On April 6, 2017 appellant, through counsel, requested a telephonic hearing. The hearing was held on October 10, 2017.

By decision dated December 21, 2017, a hearing representative affirmed the March 29, 2017 decision.

LEGAL PRECEDENT

The schedule award provision of FECA[6] and its implementing federal regulations,[7] 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

[5] On January 23, 2017 OWCP requested clarification from the DMA with regard to the date of MMI. It indicated that Dr. Watkins Campbell's report was dated July 15, 2016, but the date of her examination had been May 5, 2016. OWCP requested that the DMA provide the date of MMI. The DMA responded that the date of MMI was the date of Dr. Watkins Campbell's examination on May 5, 2016.

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

the A.M.A., *Guides* as the uniform standard applicable to all claimants.[8] For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[9]

In determining 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. With respect to the elbow, the relevant portion of the arm for the present case, reference is made to Table 15-4 (Elbow Regional Grid) beginning on page 398. After the CDX is determined from the appropriate Grid (including identification of a default grade value), the net adjustment formula is applied using the GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[10]

Regarding the application of ROM or DBI 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.*"[11] (Emphasis in the original.)
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> The Bulletin further advises:
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> "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.

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[8] *Id.* at § 10.404(a).

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

[10] *See* A.M.A., *Guides* (6th ed. 2009) 398-411. Table 15-4 also provides that, if motion loss is present for a claimant who has lateral or medial epicondylitis, impairment may alternatively be assessed using section 15.7 (ROM impairment). Such a ROM impairment stands alone and is not combined with a DBI. *Id.* at 399, 475-78; *see also J.F.*, Docket No. 18-0598 (issued July 16, 2018) (the case was remanded for further development to apply both the ROM and DBI methodologies).

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

"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.

"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.

"If the medical evidence of record is [in]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."[12]

ANALYSIS

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

The Board has previously held 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 methodologies when assessing the extent of permanent impairment for schedule award purposes.[13] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[14] 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 a 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 No. 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.[15] The record of evidence establishes

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[12] *Id*.

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

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

[15] *Supra* note 12.

that Dr. Watkins Campbell utilized the diagnosis of wrist sprain/strain in Table 15-3 and that diagnosis is followed by an asterisk which thus requires development providing consideration of appellant's loss of ROM, if any, of the upper extremity. As previously noted, the diagnosis of lateral epicondylitis also is followed by an asterisk and requires use of both the ROM and DBI methodologies for rating permanent impairment. Neither appellant's rating physician, Dr. Watkins Campbell, nor the DMA, properly followed the guidance found in FECA Bulletin No. 17-06 and their opinions therefore are insufficient for purposes of granting a schedule award.

This case shall therefore be remanded for application of OWCP procedures found in FECA Bulletin No. 17-06. On remand, if the medical evidence of record is insufficient to render a rating using the ROM and DBI methods, appellant should be referred for a physical examination to obtain the medical evidence necessary to complete the ratings.[16] After such further development of the medical evidence as is deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

[16] *Id*.

ORDER

IT IS HEREBY ORDERED that the December 21, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this decision of the Board.

Issued: December 6, 2019
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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