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

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| **C.C., Appellant** | ) | |
| **and** | ) | **Docket No. 18-0918** |
| | ) | **Issued: December 30, 2019** |
| **U.S. POSTAL SERVICE, POST OFFICE, Newtown, PA, Employer** | ) | |

*Appearances:*
*Thomas R. Uliase. 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
ALEC J. KOROMILAS, Alternate Judge

## ***JURISDICTION***

On March 28, 2018 appellant, through counsel, filed a timely appeal from a November 17, 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.[3]

[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.*

[3] The Board notes that following the November 17, 2017 decision, OWCP received additional evidence. 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 her burden of proof to establish greater than five percent permanent impairment of the left upper extremity, for which she previously received a schedule award.

## ***FACTUAL HISTORY***

This case has previously been before the Board.[4] The facts and circumstances as set forth in the Board's prior decisions are incorporated herein by reference. The relevant facts are set forth below.

On August 20, 1996 appellant, then a 45-year-old postal clerk, filed an occupational disease claim alleging that she injured her right shoulder and left wrist due to factors of her federal employment. She retired from federal service as of July 11, 1998 and has not returned to work. By decision dated September 26, 2001, OWCP accepted appellant's claim for cervical radiculopathy, mild ulnar neuropathy, and aggravation of hypermobility of the left first metacarpophalangeal joint.

On April 10, 2008 appellant filed a claim for a schedule award (Form CA-7).

On September 25, 2008 OWCP forwarded a copy of the medical record, including prior medical reports regarding permanent impairment to Dr. Arnold T. Berman, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA). In a report dated October 15, 2008, Dr. Berman concluded that based upon the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[5] appellant had eight percent permanent impairment of the left upper extremity and one percent permanent impairment of the right upper extremity utilizing Table 15-17 on page 424. He determined that appellant had reached maximum medical improvement (MMI) on August 16, 2007.

In a letter dated December 28, 2009, OWCP notified appellant that an appointment had been made to determine whether she sustained permanent impairment due to her accepted employment injury.[6] In a report dated January 13, 2010,[7] Dr. Noubar Didizian, a Board-certified orthopedic surgeon, noted appellant's history of injury and his review of the medical record, and provided findings on physical examination. He found that there was no objective orthopedic or neurologic deficit of the cervical spine or the extremities as to the accepted employment injury and thus there were no residuals. Due to the fact that his physical examination noted that appellant

[4] Docket No. 13-2082 (issued May 15, 2014); Docket No. 07-0483 (issued June 12, 2007); Docket No. 99-0300 (issued May 17, 2000).

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

[6] The second opinion physician was provided a copy of the medical record, a statement of accepted facts (SOAF), and a series of questions.

[7] On this same date it was determined by OWCP that the SOAF required updating and thus appellant would be referred back to Dr. Didizian.

had no residuals from the employment injury, Dr. Didizian would not proceed with an impairment rating.

By decision dated February 28, 2012, OWCP denied appellant's schedule award claim, finding that the medical evidence of record failed to demonstrate a measureable permanent impairment.

On March 2, 2012 appellant, through counsel, requested an oral hearing.

By decision dated May 11, 2012, a hearing representative set aside and remanded the case finding that OWCP had not properly developed the medical evidence due to an inaccurate SOAF. She ordered OWCP to update the SOAF and obtain a supplemental report from Dr. Didizian.

In a supplemental report dated October 5, 2012, Dr. Didizian noted his review of the updated SOAF and the medical record and also provided findings upon physical examination. He noted that appellant had no objective physical findings, but she had symptoms which were a basis for consideration of a permanent impairment rating. Utilizing the A.M.A., *Guides*, Table 15-18 on page 429, Dr. Didizian concluded that under the diagnosis-based impairment (DBI) methodology for peripheral nerve injuries, appellant had two percent left upper extremity permanent impairment and two percent right upper extremity permanent impairment.

The report of Dr. Didizian provided to Dr. Morley Slutsky, Board-certified in occupational medicine serving as a DMA, concluded that there was no basis for an upper extremity impairment rating for either extremity.

By decision dated January 7, 2013, OWCP denied appellant's schedule award claim.

On January 11, 2013 appellant, through counsel, requested an oral hearing. The hearing was held on April 11, 2013.

By decision dated June 12, 2013, the hearing representative affirmed the January 7, 2013 decision.

On September 11, 2013 appellant, through counsel, filed an appeal with the Board.

By decision dated May 15, 2014, the Board set aside OWCP's June 12, 2013 schedule award decision and remanded the case to OWCP for an updated SOAF and further medical development on the issue of permanent impairment for schedule award purposes.[8]

On December 1, 2014 OWCP referred appellant to Dr. Robert A. Smith, a Board-certified orthopedist, for a determination of whether she has residuals of her accepted conditions including permanent impairment of the bilateral upper extremities. In a January 16, 2015 report, Dr. Smith noted the history of appellant's employment injury and reviewed the medical record. He noted essentially normal examination findings except subluxation and hyperextension of the left thumb MP joint by 30 degrees when compared to the right side with hypermobility. Dr. Smith noted that the only condition for which there were objective findings was hypermobility of the left thumb

[8] Docket No. 13-2082 (issued May 15, 2014).

MP joint. He specifically found no objective evidence of ongoing or residual cervical radiculopathy, brachial plexopathy, or ulnar neuropathy. Dr. Smith opined that appellant reached MMI with respect to the accepted conditions on October 5, 2012. He indicated that the ratable disabling condition was the left thump MP joint dislocation or sprain as outlined in Table 15-2, Digital Regional Grid, page 392 of the A.M.A., *Guides*. Dr. Smith applied the DBI method noting that appellant's left thumb MP joint dislocation or sprain fell under a class of diagnosis (CDX) of 1 with a default value of 3 to 10 percent depending on the amount of instability present. He calculated the grade modifier for physical examination (GMPE) of 3, the grade modifier for functional history (GMFH) of 2, and no grade modifier for clinical studies (GMCS) was warranted. Applying the net adjustment formula resulted in +3, but Dr. Smith noted that the A.M.A., *Guides* provides that a grade modifier cannot result in a higher class, therefore the appropriate net adjustment was +2. He noted that, pursuant to Table 15-2, page 392, the appropriate rating for joint instability greater than 20 degrees with a net adjustment of +2 was 12 percent impairment. Dr. Smith opined that there was zero percent impairment for cervical radiculopathy, brachial plexopathy, and ulnar neuropathy. On February 5, 2015 he submitted a supplemental report converting his prior digital impairment to four percent of the upper extremity pursuant to the A.M.A., *Guides*.

Appellant was treated by Dr. Scott Fried, an osteopath Board-certified in orthopedic surgery. In reports dated February 26 and June 4, 2015, Dr. Fried diagnosed: MP Volar plate capsular injury with chronic laxity of the left thumb; disc space narrowing at C4-5, C5-6 with radiculopathy; right rotator cuff tendinitis and subacromial impingement; posterior occipital neuralgia; bilateral radial tunnel; left ulnar neuropathy; brachial plexopathy; cervical radiculopathy; thoracic neuritis; scapular winging; and carpal tunnel neuropathy secondary to work activities.

In a June 4, 2015, report, Dr. Berman serving as a DMA concurred with Dr. Smith's finding of four percent permanent impairment of the left upper extremity. With regard to cervical radiculopathy, brachial plexopathy and ulnar neuropathy, he noted Dr. Smith's examination's lack of objective findings which supported zero percent permanent impairment.

By decision dated August 3, 2015, OWCP granted appellant a schedule award for four percent permanent impairment of the left upper extremity. The period of the award ran from January 6 to April 13, 2015.

On August 13, 2015 appellant requested an oral hearing before an OWCP hearing representative. The hearing was held on November 20, 2015. In an undated statement, appellant indicated that her examination with Dr. Smith was 10 to 12 minutes in duration and he only performed a brief physical examination.

By decision dated February 23, 2016, an OWCP hearing representative affirmed the August 3, 2015 decision.

On July 19, 2016 appellant, through counsel, requested reconsideration.

In a report dated January 5, 2016, Dr. Weiss described appellant's symptoms of pain, numbness, tingling, and swelling in the cervical spine, shoulders, and elbows. He found that appellant's *Quick*DASH score for the left upper extremity was 81 and the right upper extremity was 75. Dr. Weiss diagnosed cumulative and repetitive trauma disorder, occupational cervical

spine syndrome, discogenic disease of the cervical spine C4-5 and C5-6, bilateral cervical radiculopathy, left ulnar nerve neuropathy at the cubital tunnel, chronic subluxation of the MP joint of the left hand, chronic rotator cuff tendinopathy, chronic acromioclavicular joint arthropathy to the right shoulder, and bilateral ulnar nerve neuropathy at the cubital tunnel of the elbows. Findings on examination of the cervical spine and left elbow revealed two-point discrimination of 10 millimeters in the left hand over the ulnar nerve and diminished light touch sensibility over the C8 dermatome and ulnar nerve distribution of the left and right upper extremities. Dr. Weiss opined that the accepted employment injury was the competent producing factor for her subjective and objective symptoms and his findings. He applied the A.M.A., *Guides* to his findings and the diagnosis of entrapment neuropathy.[9] Examination of the left elbow revealed GMCS of 3, GMFH of 3, and GMPE of 1 for a total of 7. Dr. Weiss explained that the GMFH was based on appellant's *Quick*DASH score which was 81 or a grade modifier 4, increasing her impairment rating to six percent.[10] He determined the left thumb MP joint subluxation was a CDX of 2 or 20 percent permanent impairment of the digit.[11] The GMFH was 2, the GMPE was 1, and the GMCS was zero. Applying the net adjustment formula he found a combined left upper extremity impairment of 12 percent. Dr. Weiss further noted right upper extremity impairment of three percent for right shoulder acromioclavicular joint arthropathy with residual loss.[12] Dr. Weiss noted that appellant reached MMI on January 5, 2016.

An electromyogram (EMG) revealed bilateral brachial plexus involving the upper and lower plexus components significantly on the right and mildly on the left, bilateral and very significant ulnar nerve impairment involving the medial across the elbow and into the right forearm, moderate bilateral posterior interosseous nerve impairment at the radial tunnel levels, mild bilateral median nerve impairments at wrist, and no evidence of cervical nerve root impairment.

On October 30, 2016 Dr. David J. Slutsky, a Board-certified orthopedic surgeon serving as a DMA, reviewed Dr. Weiss' report and disagreed with his impairment rating. The DMA indicated that there was no electrodiagnostic data included in the medical records. Pursuant to Table 15-23, page 449, A.M.A., *Guides* he found no documented ulnar motor nerve conduction delay, a history of intermittent tingling of the third, fourth, and fifth digits for GMCS of 1, GMFH 3 for the *Quick*DASH score of 81, and GMPE of 2 for two-point discrimination of 10 millimeters. The DMA noted that according to the A.M.A., *Guides*, page 406, if the GMFH differs by two or more grades from that described by the physical examination or clinical studies, the functional history is assumed unreliable and is excluded from the grading process. He combined the grade modifiers at 3 with an average of 1. The DMA noted that a grade modifier of 1 was selected with a default of 2 percent upper extremity permanent impairment. He noted that Dr. Weiss incorrectly assigned a GMCS of 3 for test findings noting that the electrodiagnostic data was not included in the records. The DMA further noted that Dr. Weiss had improperly used a GMFH of 3, but this was deemed unreliable. He further noted that Dr. Weiss found a GMPE of 1; however, the medical

[9] A.M.A., *Guides* 449, Table 15-23.

[10] *Id.* at 406, Table 15-7.

[11] *Id.* at 393, Table 15-2.

[12] *Id.* at 403 to 410, Table 15-5 to Table 15-9.

adviser explained that this was a grade modifier 2 based on the abnormal two-point discrimination testing.

With regard to the left thumb MP joint subluxation, the DMA noted that appellant was a class 1, greater than 20 degrees of MP joint hyperextension[13] pursuant to Dr. Smith's January 16, 2015 report, for a mid-range default of 10 percent impairment of the digit. Applying the net adjustment formula, he determined a net adjustment of zero for a 10 percent digit impairment or 4 percent hand impairment pursuant to Table 15-12, page 421 of the A.M.A., *Guides.*

By decision dated November 17, 2017, OWCP expanded the accepted conditions to include dislocation of the metacarpophalangeal joint of the left thumb, brachial neuritis or radiculitis not otherwise specified, sprain of the metacarpophalangeal of the hand, and neck sprain.

By separate decision dated November 17, 2017, OWCP modified the February 23, 2016 hearing decision finding an additional permanent impairment rating of one percent of the left upper extremity for a combined left upper extremity permanent impairment of five percent.

## ***LEGAL PRECEDENT***

The schedule award provisions of FECA[14] and its implementing federal regulations,[15] 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.[16] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[17]

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 digits of the hand, the relevant portion of the upper extremity for a diagnosis for the present case, reference is made to Table 15-2 (Digit Regional Grid) beginning on page 391. After the CDX is determined from the appropriate Grid (including identification of

[13] *Id.* at 393, Table 15-2.

[14] 5 U.S.C. § 8107.

[15] 20 C.F.R. § 10.404.

[16] *Id.* at § 10.404(a).

[17] 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).

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).[18]

Regarding the application of range of motion (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).
>
> "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).[19]
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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.
>
> "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 not sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence

[18] *See* A.M.A., *Guides* 398-411 (6th ed. 2009). 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 range of motion impairment stands alone and is not combined with a DBI impairment. *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).

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

necessary to complete the rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence."[20]

## ***ANALYSIS***

The Board finds that this case is not in posture for 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 range of motion (ROM) methodologies when assessing the extent of permanent impairment for schedule award purposes.[21] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[22] 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.[23] The record of evidence establishes that appellant has received a rating for permanent impairment pursuant to Table 15-2 for a diagnosis that is followed by an asterisk, which thus requires development providing consideration of appellant's loss of ROM, if any, of the scheduled member. None of the impairment ratings of record are found to have properly followed the guidance found in FECA Bulletin No. 17-06 and therefore the schedule award opinions of record are insufficient for purposes of granting a schedule award.

Proceedings before OWCP are not adversarial in nature and OWCP is not a disinterested arbiter. In a case where OWCP proceeds to develop the evidence and to procure medical evidence, it must do so in a fair and impartial manner.[24] The Board therefore finds that this case must 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 for all presently accepted conditions, appellant should be referred for a physical examination to

[20] *Id*.

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

[22] *Id.*; *see also Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[23] *Supra* note 12.

[24] *L.W.*, Docket No. 19-1208 (issued July 19, 2019); *J.G.*, Docket No. 14-1987 (issued January 21, 2015); *Walter A. Fundinger, Jr.*, 37 ECAB 200, 204 (1985).

obtain the medical evidence necessary to complete the ratings.[25] Further, the Board finds that the medical record should be reassembled to include all diagnostic testing reports which are necessary for proper consideration of the grade modifiers in assessing permanent impairment. After such further development of the medical evidence as 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 November 17, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further development consistent with this decision of the Board.

Issued: December 30, 2019
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

[25] *Id*.