United States Department of Labor
Employees' Compensation Appeals Board

G.W., Appellant	)	
and	)	**Docket No. 19-1281**
	)	**Issued: December 4, 2019**
U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, Richmond, VA, 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 May 21, 2019 appellant, through counsel, filed a timely appeal from a March 25, 2019 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 greater than one percent permanent impairment of each upper extremity, for which she previously received schedule award compensation.

FACTUAL HISTORY

This case has previously been before the Board.[3] The facts and circumstances as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

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. Appellant worked in a modified position as of 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.[4] It found that the medical evidence of record was insufficient to establish carpal tunnel syndrome as a consequential injury.

On March 1, 2016 appellant filed a claim for a schedule award (Form CA-7).

In a development letter dated March 2, 2016, OWCP requested that appellant submit an impairment evaluation from her attending physician addressing the extent of any permanent impairment due to her employment injury in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[5] It advised that it had accepted appellant's claim for bilateral other synovitis and tenosynovitis.

By decision dated April 13, 2016, OWCP denied appellant's schedule award claim. It found that she had not responded to its March 2, 2016 development letter.

On April 22, 2016 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

A telephonic hearing was held on December 7, 2016. Counsel maintained that he was submitting additional evidence in support of appellant's schedule award claim.

In a December 6, 2016 impairment evaluation, Dr. Robert W. Macht, a surgeon, reviewed appellant's complaints of bilateral pain and weakness of the hands and wrists and triggering of the thumbs. He diagnosed bilateral synovitis and tenosynovitis, bilateral thumb triggering, and

[3] Docket No. 18-0224 (issued May 9, 2018).

[4] Appellant subsequently requested reconsideration. By decision dated May 24, 2016, OWCP denied modification of its September 15, 2014 decision.

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

bilateral carpal tunnel syndrome. Citing 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 as a result of bilateral wrist tendinitis using Table 15-3 on page 395. Dr. Macht additionally determined that appellant had six percent impairment of each upper extremity due to mild carpal tunnel syndrome using Table 15-23 on page 449. He 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 had provided a rating for the conditions of trigger finger and carpal tunnel syndrome, which OWCP had not accepted as employment related.

On February 24, 2017 Dr. Macht attributed the diagnosed conditions of bilateral carpal tunnel syndrome and triggering of the thumbs to factors of appellant's federal employment. He indicated that the conditions were "part of the normal progression of tenosynovitis." 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.

In a report dated July 7, 2017, Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), found that the evidence was currently insufficient to determine the extent of any permanent impairment of the upper extremities as Dr. Macht had failed to provide range of motion (ROM) measurements of the elbows. He opined that appellant had one percent permanent impairment of each upper extremity due to elbow tendinitis using Table 15-4 of the A.M.A., *Guides*.

On July 27, 2017 OWCP requested that appellant submit a supplemental report from Dr. Macht providing three independent ROM measurements of the elbows so that it could evaluate the extent of any permanent impairment due to her bilateral elbow tendinitis. It afforded her 30 days to submit the requested evidence. No additional evidence was received.

By decision dated August 28, 2017, OWCP denied modification of its January 25, 2017 decision. It found that appellant had not submitted a report from her physician containing ROM measurements for the bilateral elbows. OWCP thus determined that she had not submitted evidence sufficient to establish a permanent impairment of the upper extremities.

Appellant appealed to the Board. By decision dated May 9, 2018, the Board set aside the August 28, 2017 decision after finding that the case was not in posture for decision.[6] The Board remanded the case for OWCP to refer appellant for a second opinion examination to obtain ROM measurements in accordance with FECA Bulletin No. 17-06.[7] The Board further noted that OWCP

[6] *Supra* note 3.

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

had initially accepted the claim for bilateral elbow tendinitis, but had advised in its March 2, 2016 development letter that it had accepted other bilateral synovitis and tenosynovitis. The Board instructed OWCP, on remand, to clarify the accepted conditions.

On June 18, 2018 OWCP referred appellant to Dr. D. Burke Haskins, a Board-certified orthopedic surgeon, for a second opinion examination. It advised him that the accepted condition was bilateral elbow tendinitis.

In a July 10, 2018 impairment evaluation, Dr. Haskins discussed appellant's symptoms of pain in the mediolateral aspect of the elbow, burning throughout her arm, stiffness, and bilateral hand numbness affecting the digits. He obtained multiple ROM measurements of the elbows showing zero degrees extension, 150 degrees flexion, and full pronation and supination. On examination of the bilateral elbows, Dr. Haskins found no specific tenderness over the medial or lateral epicondyle and a negative Tinel's sign. He diagnosed nonspecific elbow pain. Dr. Haskins identified the class of diagnosis (CDX) as class 1 elbow pain using Table 15-4 on page 398 of the A.M.A., *Guides*, which yielded a default impairment rating of one percent. He found a *Quick*DASH (Disabilities of the Arm, Shoulder, and Hand) score of 112.5, for a grade modifier for functional history (GMFH) of four. Dr. Haskin noted that appellant also had complaints of bilateral carpal tunnel syndrome and trigger finger. He concluded that a GMFH of four was unreliable as it varied by two or more grades from the score for physical examination and clinical studies. Dr. Haskin found a grade modifier for physical examination (GMPE) of one and that a grade modifier for clinical studies (GMCS) was used to identify the diagnosis and thus not applicable. He applied the net adjustment formula and found no change from the default value of one percent. Dr. Haskin further advised that appellant had no impairment due to loss of ROM. He opined that she had reached maximum medical improvement (MMI) on July 10, 2018.

On July 17, 2018 Dr. Harris concurred with Dr. Haskins' finding of one percent permanent impairment of each upper extremity using the diagnosis-based impairment (DBI) method and no impairment of either upper extremity using the ROM method.

By decision dated July 31, 2018, OWCP granted appellant a schedule award for one percent permanent impairment of each upper extremity. The period of the award ran for 6.24 weeks from July 10 to August 22, 2018.

On August 8, 2018 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

A telephonic hearing was held on January 10, 2019. Appellant described the pain in her elbows and the stiffness and tingling of her hands and fingers. She asserted that Dr. Macht's impairment rating better reflected the damage to her upper extremities.

By decision dated March 25, 2019, OWCP's hearing representative affirmed the July 31, 2018 decision.[8]

[8] OWCP's hearing representative additionally found that OWCP should update its diagnosis code to reflect that the accepted condition was bilateral elbow tendinitis.

LEGAL PRECEDENT

The schedule award provision of FECA,[9] and its implementing federal regulation,[10] 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 loss of a member shall be determined. The method used in making such a determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*, published in 2009.[11] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[12]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning Disability and Health (ICF).[13] Under the sixth edition, the evaluator identifies the impairment class of diagnosis (CDX), which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE) and clinical studies (GMCS).[14] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[15] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[16]

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

[9] *Supra* note 2.

[10] 20 C.F.R. § 10.404.

[11] For decisions issued after May 1, 2009 the sixth edition of the A.M.A., *Guides* is used. A.M.A., *Guides*, (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6 (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[12] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[13] A.M.A., *Guides* (6th ed. 2009), p.3, section 1.3, International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[14] *Id*. at 494-531.

[15] *Id*. at 411.

[16] *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

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.)[17]

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."[18]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish greater than one percent permanent impairment of each upper extremity, for which she previously received schedule award compensation.

In the prior appeal, the Board found that the evidence from Dr. Macht was insufficient to establish the extent of appellant's permanent impairment of the upper extremities. Findings made in prior Board decisions are *res judicata* absent further review by OWCP under section 8128 of FECA and therefore the prior evidence need not be addressed again in this decision.[19]

OWCP referred appellant to Dr. Haskins for an impairment evaluation. On July 10, 2018 Dr. Haskins measured ROM of the bilateral elbows as 150 degrees flexion, 0 degrees extension, and full pronation and extension, which yielded no ratable impairment for ROM.[20] Using the DBI method, he identified the CDX as elbow pain using Table 15-4 on page 398, which yielded a default value of one percent. Dr. Haskins found a GMPE of one and that a GMCS was inapplicable as it was used to identify the CDX. He further found that appellant's GMFH score of four was unreliable. Using the net adjustment formula yielded no change from the default value of one percent.[21] Dr. Haskins found that appellant had one permanent impairment of each upper

[17] FECA Bulletin No. 17-06 (May 8, 2017); *see also W.H.*, Docket No. 19-0102 (issued June 21, 2019).

[18] *Id*.

[19] *See* 20 C.F.R. § 501.6(d); *S.C.*, Docket No. 19-0920 (issued September 25, 2019).

[20] A.M.A., *Guides* 474, Table 15-33.

[21] Utilizing the net adjustment formula discussed above, (GMPE-CDX), or (1-1) = 0, yielded a zero adjustment.

extremity using the DBI method and no impairment using the ROM method. He determined that she had obtained MMI.

On July 17, 2018 Dr. Harris, the DMA, reviewed Dr. Haskins' report and concurred with his impairment rating. He properly found that it was appropriate to rate appellant's impairment using the DBI method as she had no loss of ROM.[22]

The record contains no current medical evidence conforming to the sixth edition of the A.M.A., *Guides* demonstrating greater than one percent permanent impairment of each upper extremity due to the accepted employment injury. Consequently, the Board finds that appellant has not met her burden of proof to establish entitlement to a greater schedule award.[23]

Appellant may request a schedule award or increased schedule award at any time based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish greater than one percent permanent impairment of each upper extremity, for which she previously received schedule award compensation.

[22] *See W.H.*, Docket No. 19-0102 (issued June 21, 2019).

[23] *L.L.*, Docket No. 19-0855 (issued September 24, 2019).

ORDER

IT IS HEREBY ORDERED THAT the March 25, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 4, 2019
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