United States Department of Labor
Employees' Compensation Appeals Board

P.E., Appellant	)	
and	)	**Docket No. 18-0745**
	)	**Issued: February 6, 2019**
U.S. POSTAL SERVICE, POST OFFICE, Phillipsburg, NJ, Employer	)	

Appearances:
Michael D. Overman, 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 February 23, 2018 appellant, through counsel, filed a timely appeal from an October 26, 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 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 her burden of proof to establish more than 14 percent permanent impairment of the right upper extremity and 10 percent permanent impairment of the left upper extremity, for which she previously received schedule award compensation.

FACTUAL HISTORY

On November 5, 2010 appellant, then a 54-year-old custodian, filed a traumatic injury claim (Form CA-1) alleging that, earlier that day, she tripped and fell forward over a bucket of mail, striking her head, face, and right shoulder while in the performance of duty. She stopped work on the date of injury and was treated at a hospital emergency department. On December 21, 2010 OWCP accepted the claim for facial contusion. It paid appellant wage-loss compensation commencing January 8, 2011.[4]

On November 17, 2015 appellant filed a claim for a schedule award (Form CA-7). In support of her claim, she provided a July 7, 2014 impairment rating from Dr. Arthur Becan, an orthopedic surgeon, who summarized her history of injury and treatment, and opined that she had attained maximum medical improvement (MMI). Regarding the right upper extremity, Dr. Becan referred to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[5] and *The Guides Newsletter, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*). He found a class of diagnosis (CDX) for sensory deficit of the right C5 nerve root, equaling four percent upper extremity impairment. Dr. Becan noted a grade modifier for functional history (GMFH) for a pain disability questionnaire (PDQ) score of 73, and a grade modifier for clinical studies (GMCS) of 4. Applying the net adjustment formula of (GMFH - CDX) + (GMCS - CDX), or (2-1) + (4-1) resulted in a net adjustment of 4, equaling four percent permanent impairment of the right upper extremity. Utilizing the same method of calculation, Dr. Becan found six percent permanent impairment of the right upper extremity due to C6 nerve root impairment, and four percent permanent impairment of the right upper extremity due to impairment of the C7 nerve root. He also found five percent permanent impairment of the right arm due to a class 1 mild IV/V motor strength deficit of the right deltoid, enervated by the right C6 nerve root. Dr. Becan applied the net adjustment formula (GMFH - CDX) + (GMCS - CDX), (2-1) + (4-1), which yielded a net adjustment of 4, raising the five percent impairment upward to nine percent. He also addressed entrapment neuropathy at the right wrist. Referring to Table 15-23, Dr. Becan found 6 percent permanent impairment of the right upper extremity due to entrapment neuropathy at the right median nerve, based on a grade modifier for physical examination (GMPE) findings of 3 for decreased pinch strength and a GMFH of 3 for a *Quick*DASH score of 68 percent. He combined these percentage values to total 25 percent permanent impairment of the right upper extremity.

[4] By decision dated April 18, 2013, OWCP terminated appellant's wage-loss compensation and schedule award eligibility, effective that day as she refused an offer of suitable work, pursuant to 5 U.S.C. § 8106(c)(2). Following a telephonic hearing before an OWCP hearing representative on August 22, 2013, by decision dated December 9, 2013, an OWCP hearing representative reversed the April 18, 2013 decision and reinstated appellant's wage-loss compensation payments and schedule award eligibility.

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

Regarding the left upper extremity, Dr. Becan again referred to the A.M.A., *Guides* July/August 2009 *Guides Newsletter*. He found a class 1 CDX for sensory deficit of the right C5 nerve root, equaling 3 percent impairment, a GMFH for a PDQ score of 73, and a GMCS of 4. Applying the net adjustment formula of (GMFH - CDX) + (GMCS - CDX), or (2-1) + (4-1) resulted in a net adjustment of 4, equaling three percent permanent impairment of the left upper extremity. Utilizing the same method of calculation, Dr. Becan found five percent permanent impairment of the right upper extremity due to C6 nerve root impairment, and three percent permanent impairment of the right upper extremity due to impairment of the C7 nerve root. He also found five percent permanent impairment of the left arm due to a class 1 mild IV/V motor strength deficit of the right deltoid. Dr. Becan applied the net adjustment formula (GMFH - CDX) + (GMCS - CDX), (2-1) + (4-1), which yielded a net adjustment of 4, raising the five percent impairment upward to nine percent. He also found five percent permanent impairment of the right upper extremity due to a class 1 mild IV/V motor strength deficit of the right deltoid, enervated by the right C6 nerve root, adjusted upward to nine percent based on a GMFH of 2 and a GMCS of 4. Dr. Becan also addressed entrapment neuropathy at the left wrist. Referring to Table 15-23, he found 6 percent permanent impairment of the left upper extremity due to entrapment neuropathy at the left median nerve, based on a GMPE findings of 3 for decreased pinch strength and a GMFH of 2 for a *Quick*DASH (Disabilities of the Arm, Shoulder, and Hand) score of 47 percent. Dr. Becan combined these percentage values to total 22 percent permanent impairment of the left upper extremity.

In a February 3, 2016 report, Dr. David I. Krohn, a Board-certified internist and OWCP district medical adviser (DMA), reviewed Dr. Becan's opinion. He noted that OWCP had not accepted a cervical spine injury or carpal tunnel syndrome. Dr. Krohn opined that the accepted facial contusion had not caused a permanent impairment of a scheduled member of the body.

OWCP found a conflict of medical opinion evidence between Dr. Becan for appellant, and Dr. Krohn, for the government, regarding the appropriate percentage of permanent impairment. To resolve the conflict, it selected Dr. Dean Carlson, a Board-certified orthopedic surgeon, as an impartial medical specialist. Dr. Carlson submitted a July 28, 2016 report in which he reviewed the medical record and a statement of accepted facts (SOAF). He related appellant's symptoms of bilateral shoulder pain and dysfunction and bilateral hand pain and paresthesias. Appellant reported that her shoulder motion was so limited she could not wash her back. On examination, Dr. Carlson found limited motion of the cervical spine, both shoulders, and both wrists, weakness of both shoulders, grip strength at 15 pounds on the right and 25 pounds on the left, and diminished light-touch sensation over the right radial thenar eminence and to the volar aspect of the fingers of the left hand. He obtained x-rays of both shoulders which demonstrated degenerative arthritis of the humeral head with osteophyte formation. Dr. Carlson diagnosed a resolved facial contusion by history, bilateral idiopathic glenohumeral arthritis, right C5, C6, and C7 radiculopathy, left C7 radiculopathy, and bilateral carpal tunnel syndrome. He opined that the accepted November 5, 2010 occupational injury caused or aggravated the cervical radiculopathy and bilateral carpal tunnel syndrome. Dr. Carlson explained that appellant's bilateral glenohumeral arthritis was not traumatic. He noted that she had attained MMI as of July 7, 2014.

Regarding the right upper extremity, Dr. Carlson found a CDX of 1 for C5 radiculopathy with mild sensory deficit of the right hand according to the *Guides Newsletter*, equaling 1 percent permanent impairment of the right upper extremity. He assessed a moderate motor deficit of 9 percent according to Table 15-14, resulting in 10 percent permanent impairment of the right upper

extremity. Dr. Carlson opined that the "grade modifiers did not come into play" as the GMCS of 3 did not alter the rating, and there was no applicable GMFH as he could not use the *Quick*DASH score. He found that the right C6 radiculopathy "exhibited a moderate sensory rating of three percent and a mild motor rating of five percent for 4/5 grip weakness, totaling eight percent. However, as appellant had multiple simultaneous neuropathies, she received only 50 percent of that score, so the combined upper extremity impairment of the C5 and C6 radiculopathy is 10 percent plus 4 percent equaling 14 percent." Her "C7 radiculopathy and right median nerve entrapment at the wrist fell under the criteria of multiple simultaneous neuropathies" rule at page 448 of the A.M.A., *Guides*, and were therefore not rated. Dr. Carlson combined the 10 percent and 4 percent impairments for a combined 14 percent permanent impairment of the right upper extremity.

Regarding the left upper extremity, Dr. Carlson noted that the C7 radiculopathy had a moderate sensory impairment equaling 2 percent impairment of the left arm, but a "mild motor score of [5] percent," equaling 7 percent permanent impairment of the left upper extremity with no applicable grade modifiers. He opined that the left carpal tunnel syndrome had a GMCS of 1, GMFH of 3, and GMPE of 3, resulting in an average modifier of 2. As the *Quick*DASH score could not be used, the default CDX of five percent remained unchanged. Utilizing the multiple simultaneous neuropathies grading method, Dr. Carlson reduced the 5 percent impairment for carpal syndrome by 50 percent, equaling 2.5, rounded up to 3 percent. He combined the 7 percent impairment for C7 radiculopathy and 3 percent impairment for carpal tunnel syndrome to equal 10 percent permanent impairment of the left upper extremity.

In a report dated December 26, 2016, Dr. James W. Butler, a DMA Board-certified in occupational medicine, reviewed the medical record and SOAF. He opined that Dr. Carlson properly applied the appropriate portions of the A.M.A., *Guides* to appellant's upper extremity conditions.

By decision dated March 21, 2017, OWCP expanded acceptance of appellant's claim to include a neck sprain and lumbar sprain. It granted her a schedule award for 14 percent permanent impairment of the right upper extremity and 10 percent permanent impairment of the left upper extremity. The period of the award ran from July 7, 2014 to December 13, 2015.

On March 28, 2017 counsel requested a hearing before an OWCP hearing representative. During the hearing, held on August 16, 2017, he contended that Dr. Carlson had failed to provide a GMFH, ignored the *Quic*kDASH score, and failed to provide an impairment rating for osteoarthritis of the shoulder. Counsel requested that OWCP remand the case to obtain a supplemental report from Dr. Carlson. He submitted additional medical evidence.

In a report dated August 28, 2017, Dr. Becan reviewed Dr. Carlson's report and contended that he had erred in applying the multiple simultaneous neuropathies grading model. He explained that, according to page 448 of the A.M.A., *Guides*, the multiple simultaneous neuropathies model applied only to "concurrent focal nerve compromise in the same upper limb, such as simultaneous carpal tunnel syndrome and ulnar neuropathy at the elbow." As cervical radiculopathy was not a focal entrapment neuropathy, Dr. Carlson should not have characterized it as such in his impairment rating. Dr. Becan also contended that, although Dr. Carlson found that the GMFH could not be used, the *Guides Newsletter* mandated that GMFH should be included for each nerve impairment. He also questioned why Dr. Carlson had not found moderate sensory deficit in the

left C5 and C6 dermatomes as was apparent on Dr. Becan's July 7, 2014 examination. Dr. Becan concluded that appellant had 22 percent permanent impairment of the left upper extremity and 24 percent permanent impairment of the right upper extremity.

By decision dated October 26, 2017, OWCP's hearing representative affirmed the March 21, 2017 schedule award. He noted that Dr. Carlson had properly applied the multiple simultaneous neuropathies rule and rejected the *Quick*DASH scores as inconsistent with the accepted injuries.

LEGAL PRECEDENT

The schedule award provisions 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 specified members of the body. However, FECA does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound 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. The A.M.A., *Guides* has been adopted by OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[8] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*.[9]

No schedule award is payable for a member, function, or organ of the body not specified in FECA or in the regulations.[10] Because neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the spine,[11] no claimant is entitled to such an award.[12] However, in 1966, amendments to FECA modified the schedule award provision to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. As the schedule award provision of FECA includes the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[13]

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. For peripheral nerve impairments to the upper or

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. §10.404.

[8] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (March 2017); *see also id.* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[10] *Henry B. Floyd, III*, 52 ECAB 220 (2001).

[11] FECA specifically excludes the back from the definition of "organ." 5 U.S.C. § 8101(19).

[12] *Thomas Martinez*, 54 ECAB 623 (2003).

[13] *See Thomas J. Engelhart*, 50 ECAB 319 (1999).

lower extremities resulting from spinal injuries, OWCP's procedures indicate that *The Guides Newsletter* is to be applied.[14] The Board has long recognized the discretion of OWCP to adopt and utilize various editions of the A.M.A., *Guides* for assessing permanent impairment.[15] In particular, the Board has recognized the adoption of this methodology for rating extremity impairment, including the use of *The Guides Newsletter*, as proper in order to provide a uniform standard applicable to each claimant for a schedule award for extremity impairment originating in the spine.[16]

The A.M.A., *Guides* specifically provides that, if multiple simultaneous neuropathies occur in the same limb, both impairments may be rated and the nerve qualifying for the larger impairment is given the full impairment while the nerve qualifying for the smaller impairment is rated at 50 percent.[17] The A.M.A., *Guides* further indicate that Table 15-23 is to be used for rating focal nerve compromise.[18]

Section 8123(a) of FECA provides that when there is a disagreement between the physician making the examination for the United States and the physician of the employee, a third physician shall be appointed to make an examination to resolve the conflict.[19] When there are opposing medical reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a), to resolve the conflict in the medical evidence.[20] In situations where there are opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[21] However, in a situation where OWCP secures an opinion from an impartial medical examiner for the purpose of resolving a conflict in the medical evidence and the opinion from such examiner requires clarification or elaboration, OWCP has the responsibility to secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion.[22]

[14] *See G.N.*, Docket No. 10-0850 (issued November 12, 2010); *see also supra* note 9 at Chapter 3.700, Exhibit 1, note 5 (January 2010). *The Guides Newsletter* is included as Exhibit 4.

[15] *D.S.*, Docket No. 14-0012 (issued March 18, 2014).

[16] *See A.R.*, Docket No. 17-1504 (issued May 25, 2018); *E.D.*, Docket No. 13-2024 (issued April 24, 2014); *D.S.*, Docket No. 13-2011 (issued February 18, 2014).

[17] A.M.A., *Guides* 448.

[18] *Id.*

[19] 5 U.S.C. § 8123(a); *Robert W. Blaine*, 42 ECAB 474 (1991).

[20] *Delphia Y. Jackson*, 55 ECAB 373 (2004).

[21] *Anna M. Delaney*, 53 ECAB 384 (2002).

[22] *Margaret M. Gilmore*, 47 ECAB 718 (1996).

ANALYSIS

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

In support of her schedule award claim, appellant submitted a report dated July 7, 2014 from Dr. Becan, an orthopedic surgeon. Regarding the right upper extremity, Dr. Becan found that she had 24 percent permanent impairment of the right upper extremity. Regarding the left upper extremity, he found 22 percent permanent impairment of the left upper extremity. OWCP referred the record to Dr. Krohn, an OWCP DMA, who opined that in a report dated February 3, 2016 that the accepted facial contusion did not result in permanent impairment of a scheduled member of the body.

OWCP properly found a conflict of medical opinion between Dr. Becan, for appellant, and Dr. Krohn, for the government, and selected Dr. Carlson as impartial medical examiner in the case.

Dr. Carlson provided a July 28, 2016 report. He opined that the accepted November 5, 2010 employment injury had caused cervical and lumbar spine sprains in addition to a resolved facial contusion. Dr. Carlson rated appellant's percentage of permanent impairment based on the Multiple Simultaneous Neuropathies rule at page 448 of the A.M.A., *Guides*. This rating method applies to "[m]ultiple, concurrent focal nerve compromise syndromes in the same upper limb," such as simultaneous carpal tunnel syndrome and ulnar neuropathy.[23] "The nerve qualifying for the larger impairment is given the full impairment. The nerve qualifying for the smaller impairment is rated at 50 percent (one-half) of the impairment listed in Table 15-23" at page 229 of the A.M.A., *Guides*, titled "Entrapment/Compression Neuropathy Impairment."

Referring to the multiple simultaneous neuropathies rule, Dr. Carlson characterized the C5, C6, and C7 nerve root entrapments as peripheral, focal neuropathies. Utilizing the multiple simultaneous neuropathy formula for the right upper extremity, he found 10 percent permanent impairment for C5 nerve root compromise, 8 percent permanent impairment for C6 nerve root compromise reduced by 50 percent to 4 percent, and no applicable rating for C7 nerve root compromise and carpal tunnel syndrome, for a combined 14 percent permanent impairment of the right upper extremity. Applying the same rating methodology to the left upper extremity, Dr. Carlson found 7 percent permanent impairment for C7 nerve root compromise, and 5 percent permanent impairment for carpal tunnel syndrome reduced to 2.5 percent then rounded upward to 3 percent, for a combined 10 percent permanent impairment. Dr. Butler, a DMA, concurred with Dr. Carlson. OWCP predicated its March 21, 2017 schedule award decision on Dr. Carlson's impairment rating as reviewed by Dr. Butler.

Following an oral hearing before an OWCP hearing representative, counsel submitted a report dated August 28, 2017 from Dr. Becan, who explained that Dr. Carlson mischaracterized cervical nerve root entrapment as a focal, peripheral neuropathy under the multiple simultaneous neuropathies rule. By decision dated October 26, 2017, OWCP affirmed the March 21, 2017 schedule award determination. The Board finds, however, that Dr. Carlson did not specify which portion of the A.M.A., *Guides* allowed for rating impingement of cervical nerve roots, a pathology occurring in the cervical spine, as a focal, peripheral entrapment neuropathy occurring in an upper

[23] *Supra* note 17.

extremity. Dr. Carlson's report thus requires clarification.[24] Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. OWCP shares responsibility to see that justice is done.[25] On remand, OWCP shall prepare an updated SOAF and request that Dr. Carlson clarify his report to address the issue raised by Dr. Becan. After such further development of the medical evidence as deemed necessary, it shall issue a *de novo* decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the October 26, 2017 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for additional development consistent with this opinion.

Issued: February 6, 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

[24] *See supra* note 9 at Part 3 -- Medical, *OWCP-Directed Medical Examinations,* Chapter 3.500.4g(3)(b) (July 2011). *See also supra* note 22.

[25] *Jimmy A. Hammons*, 51 ECAB 219 (1999).