United States Department of Labor
Employees' Compensation Appeals Board

J.M., Appellant	)	
and	)	**Docket No. 18-1387**
	)	**Issued: February 1, 2019**
U.S. POSTAL SERVICE, POST OFFICE, Southeastern, 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 July 6, 2018 appellant, through counsel, filed a timely appeal from a February 2, 2018 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 his burden of proof to establish more than three percent permanent impairment of the right upper extremity, for which he previously received schedule award compensation.

FACTUAL HISTORY

On February 9, 2011 appellant, then a 61-year-old mail handler, filed an occupational disease claim (Form CA-2) alleging that he sustained right carpal tunnel syndrome causally related to factors of his federal employment. OWCP accepted the claim, assigned File No. xxxxxx074, for right carpal tunnel syndrome. On May 27, 2011 appellant underwent a medial nerve decompression and flexor tenosynovectomy of the right wrist.

OWCP had previously accepted under File No. xxxxxx389 that appellant sustained contusions of the right elbow, left hand, and left knee, a complicated laceration of the right elbow, other enthesopathy of the right elbow, and right olecranon bursitis due to a March 4, 2006 injury. Electrodiagnostic testing performed on September 29, 2008 revealed bilateral median focal demyelination at the carpal tunnel.

Under File No. xxxxxx389, by decision dated August 10, 2010, OWCP granted appellant a schedule award under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[3] for two percent permanent impairment of the right upper extremity due to right elbow olecranon bursitis. By decision dated June 13, 2012, it granted him an additional award for one percent permanent impairment of the right upper extremity due to right elbow olecranon bursitis.

OWCP additionally accepted that appellant sustained a cervical sprain on February 8, 2008 under File No. xxxxxx350 and left carpal tunnel syndrome and left trigger finger under File No. xxxxxx142. Appellant underwent a left carpal tunnel release on January 27, 2011. By decision dated June 24, 2012, OWCP granted him a schedule award for five percent permanent impairment of the left upper extremity under File No. xxxxxx142.

On May 27, 2011 Dr. A. Lee Osterman, a Board-certified orthopedic surgeon, performed a right carpal tunnel release. Appellant stopped work on May 27, 2011 and returned to full-duty employment on August 21, 2011.

In a January 10, 2012 report, Dr. David Weiss, an osteopath, opined that, pursuant to Table 15-23 on page 449 the sixth edition of the A.M.A., *Guides*, appellant had five percent permanent impairment of the right upper extremity due to entrapment neuropathy. He further found that he had two percent permanent impairment of the right elbow due to olecranon bursitis, for eight percent combined right upper extremity impairment. Dr. Weiss also found five percent permanent impairment of the left upper extremity due to entrapment neuropathy.

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

Appellant, on May 11, 2012, filed a claim for a schedule award (Form CA-7).

Dr. Arnold T. Berman, a Board-certified orthopedic surgeon acting as district medical adviser (DMA), reviewed the case record on June 18, 2012 and opined that appellant had five percent permanent impairment of each upper extremity due to entrapment neuropathy under Table 15-23. He noted that OWCP had not accepted elbow olecranon bursitis under the current file number.

By decision dated March 27, 2013, OWCP denied appellant's claim for an increased schedule award. It found that the evidence of record established that he had no more than the previously awarded three percent right upper extremity impairment under File No. xxxxxx389.

On April 1, 2013 appellant, through counsel, requested an oral hearing before an OWCP hearing representative.

Following a preliminary review, by decision dated June 24, 2013, OWCP's hearing representative vacated the March 27, 2013 decision. She noted that Dr. Weiss had provided examination findings that significantly differed from those of appellant's attending physician, and thus remanded the case for OWCP to refer him for a second opinion examination. The hearing representative instructed OWCP to combine all of his upper extremity claims before determining the extent of his right upper extremity impairment.

OWCP subsequently administratively combined File Nos. xxxxxx389, xxxxxx142, xxxxxx350, and xxxxxx074, with xxxxxx074 serving as the master file.

On August 23, 2013 OWCP referred appellant to Dr. Robert F. Draper, a Board-certified orthopedic surgeon, for a second opinion examination to determine the extent of appellant's permanent impairment of his right upper extremity. In a September 20, 2013 report, Dr. Draper found that he had five percent permanent impairment of the right upper extremity impairment due to carpal tunnel syndrome under Table 15-23 of the A.M.A., *Guides*. He further found two percent permanent impairment of the right elbow using the elbow regional grid set forth at Table 15-4, for a combined right upper extremity impairment of seven percent. Dr. Draper additionally opined that appellant had five percent permanent impairment of the left upper extremity.

Dr. Morley Slutsky, an occupational medicine specialist serving as a DMA, reviewed the evidence on October 14, 2013 and opined that appellant had two percent permanent impairment due to right carpal tunnel syndrome and two percent permanent impairment due to right olecranon bursitis, for four percent permanent impairment of the right upper extremity. He further found one percent permanent impairment of the left upper extremity due to carpal tunnel syndrome.

By decision dated October 16, 2013, OWCP denied appellant's claim for an increased schedule award based on the DMA's finding that he had no more than the previously awarded three percent permanent impairment of the right upper extremity and five percent permanent impairment of the left upper extremity.

On October 22, 2013 appellant, through counsel, requested an oral hearing.

Following a February 19, 2014 oral hearing, by decision dated May 9, 2014, OWCP's hearing representative vacated the October 16, 2013 decision. She found that a conflict existed between the DMA and Dr. Weiss regarding the extent of appellant's permanent impairment of the right upper extremity and remanded the case for OWCP to refer him for an impartial medical examination.

OWCP, on July 16, 2014, referred appellant to Dr. Noubar Didizian, a Board-certified orthopedic surgeon, for an impartial medical examination. In a report dated August 26, 2014, Dr. Didizian discussed appellant's symptoms of right elbow soreness when leaning against objects, a loss of complete extension after prolonged flexion of the elbow, and a loss of grip strength in his hands. On examination, he measured elbow motion as 3 to 140 degrees on the right side with no synovitis and a negative Tinel's sign at the cubital tunnel. For the right wrist, Dr. Didizian found no synovitis, tenosynovitis, or ligamentous instability, with a "hint of minimal atrophy of the right abductor pollicis brevis," but full strength. He found that appellant had three percent permanent impairment of the right upper extremity due to carpal tunnel syndrome using Table 15-23 of the A.M.A., *Guides*. Dr. Didizian applied a grade modifier of one for conduction delay, and grade modifier of one for minimal physical findings, noting that the functional scale was normal. He further determined that appellant had one percent permanent impairment due to olecranon bursitis with no objective findings, for a total of four percent permanent impairment of right upper extremity.

Dr. Slutsky reviewed the record on September 11, 2015. He requested that Dr. Didizian again review Table 15-23 and apply the normal functional score in reaching an impairment rating. Dr. Slutsky further indicated that he should apply the *Quick*DASH (Disabilities of the Arm, Shoulder, and Hand) in calculating the extent of impairment. He also requested that Dr. Didizian explain how clinical studies yielded a grade modifier of two in rating appellant's right elbow olecranon bursitis under Table 15-14 on page 398.

In an October 29, 2015 supplemental report, Dr. Didizian advised that he had utilized a *Quick*DASH analysis in questioning appellant regarding his daily activities. He found a normal functional score and, on the basis of tests results, history, and physical findings, concluded that appellant had three percent permanent impairment due to carpal tunnel syndrome under Table 15-23 on page 449.

On January 14, 2016 Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as a DMA, found that Dr. Didizian erred in applying Table 15-23 as a normal functional grade modifier yielded a grade zero rather than a grade two impairment. He found that appellant had one percent permanent impairment of the right upper extremity due to his carpal tunnel syndrome. Dr. Katz further found that he had two percent impairment for olecranon bursitis rather than one percent as found by Dr. Didizian, for three percent total right upper extremity impairment.

By decision dated February 10, 2016, OWCP denied appellant's claim for an increased schedule award for the right upper extremity. It found that the opinion of Dr. Katz represented the weight of the evidence and established that he had no more than three percent right upper extremity impairment.

On February 19, 2016 appellant, through counsel, requested an oral hearing.

By decision dated April 22, 2016, following a preliminary review, an OWCP hearing representative vacated the February 10, 2016 decision. He found that the impartial medical examiner (IME), rather than the DMA, should resolve the conflict in medical opinion. The hearing representative instructed OWCP to obtain clarification from Dr. Didizian regarding his impairment determination.

Dr. Didizian, in an August 14, 2016 supplemental report, related that in rating appellant's impairment due to carpal tunnel syndrome under Table 15-23, he had applied a grade modifier of one based on positive electrodiagnostic testing. He had applied a grade modifier of one for history based on mild symptoms and grade modifiers of zero for functional scale and physical findings. Dr. Didizian found that the impairment range for a grade 1 modifier was one to three percent. He indicated that he should have added the grade modifiers for test findings and history and divided by two, to find one percent permanent impairment of the right upper extremity under Table 15-23.

By decision dated August 19, 2016, OWCP denied appellant's claim for an additional schedule award for the right upper extremity, noting that Dr. Didizian concurred with Dr. Katz's finding of three percent right upper extremity impairment.

Appellant, through counsel, on August 31, 2016 requested an oral hearing before an OWCP hearing representative.

Following a preliminary review, by decision dated November 30, 2016, OWCP's hearing representative set aside the August 19, 2016 decision. She found that Dr. Didizian had failed to adequately address the DMA's questions regarding the rating of appellant's elbow condition, noting that Dr. Katz found that he had two percent permanent impairment due to his bursitis.

In another supplemental report dated February 17, 2017, Dr. Didizian identified the right elbow impairment as class 1 olecranon bursitis, which yielded a default value of two percent. He applied grade modifiers of one for clinical studies and functional history, and a grade modifier of zero for physical examination findings, to find a net adjustment of minus one, which yielded two percent permanent impairment. Regarding appellant's carpal tunnel syndrome, Dr. Didizian found grade modifiers of one for positive test results and history, for an average grade modifier of one and a right upper extremity impairment of one percent. He combined the impairment ratings to find that appellant had a total of three percent right upper extremity impairment.

Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a DMA, reviewed the evidence on March 24, 2017. Referencing Dr. Didizian's August 26, 2014 report, he found that appellant had one percent impairment due to olecranon bursitis of the right elbow using Table 15-4 on page 398 and three percent impairment due to mild carpal tunnel syndrome using Table 15-23 on page 449, for a total of four percent permanent impairment of the right upper extremity. Dr. Harris advised that he had no impairment of the left upper extremity. He opined that appellant had reached maximum medical improvement on August 26, 2014, the date of Dr. Didizian's evaluation.

By decision dated March 31, 2017, OWCP granted appellant a schedule award for an additional one percent permanent impairment of the right upper extremity, for a total right upper

extremity rating of four percent. The period of the award ran for 3.12 weeks from August 13 to September 3, 2014.

On April 6, 2017 appellant, through counsel, requested an oral hearing before an OWCP hearing representative.

During the hearing, held on July 19, 2017, counsel asserted that Dr. Didizian's February 14, 2017 report was not reasoned and was thus insufficient to resolve the conflict in medical opinion. He noted that Dr. Didizian had failed to explain why his assignment of grade modifiers differed from that of Dr. Weiss.

By decision dated August 22, 2017, OWCP's hearing representative affirmed the March 31, 2017 decision, as modified to find that appellant had no more than three percent permanent impairment of the right upper extremity. He found that Dr. Didizian's opinion represented the special weight of the evidence and that Dr. Harris' finding of four percent permanent right upper extremity impairment was not supported by the evidence, noting that he based the finding on Dr. Didizian's August 26, 2014 report rather than his February 14, 2017 addendum. The hearing representative further determined that, as Dr. Didizian found normal range of elbow motion, there was no basis for an award due to loss of range of motion of the elbow pursuant to FECA Bulletin No. 17-06.[4]

OWCP subsequently received an August 21, 2017 report from Dr. Weiss, who advised that under Table 15-4 at page 398 of the A.M.A., *Guides*, appellant had two percent permanent impairment due to right elbow olecranon bursitis. Dr. Weiss indicated that he and Dr. Didizian both found a grade modifier of one for test findings, but disagreed on the grade modifier for physical findings. He noted that atrophy would constitute a grade three modifier for physical examination findings. Dr. Weiss disagreed with Dr. Didizian's finding that appellant's history of carpal tunnel syndrome was mild based on his bilateral hand numbness upon awakening, and found a grade two modifier for history. He opined that he had five percent permanent impairment due to right carpal tunnel syndrome, for a total right upper extremity impairment of eight percent. Dr. Weiss also noted that appellant had a permanent impairment of the left upper extremity.

On September 5, 2017 appellant, through counsel, requested reconsideration.

By decision dated February 2, 2018, OWCP denied modification of its August 22, 2017 decision. It noted that Dr. Weiss rendered his opinion approximately five years from the time he examined appellant and was insufficient to overcome the weight afforded Dr. Didizian as the IME.

On appeal counsel asserts that when Dr. Didizian failed to clarify his opinion after multiple request by OWCP, it should have referred appellant for a new impartial medical examination. He maintains that his opinion is not rationalized and is thus insufficient to resolve the conflict in medical opinion.

[4] FECA Bulletin No. 17-06 (issued May 8, 2017). The hearing representative further noted that Dr. Weiss had not provided range of motion measurements.

LEGAL PRECEDENT

The schedule award provision of FECA,[5] and its implementing federal 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. 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.[7] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[8]

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, reference is made to Table 15-4 (Elbow Regional Grid) beginning on page 398. After the class of diagnosis (CDX) is determined from the Shoulder Regional Grid (including identification of a default grade value), the impairment class is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE) and clinical studies (GMCS).[9] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

FECA Bulletin No. 17-06 provides guidance in applying range of motion or diagnosis-based impairment methodologies in rating permanent impairment of the upper extremities.[10]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[11] In Table 15-23, grade modifier levels (ranging from zero to four) are described for the categories of test findings, history and physical findings. The grade modifiers are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value.

FECA provides that if there is disagreement between an OWCP-designated physician and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[12] For a conflict to arise, the opposing physicians' viewpoints must be of "virtually equal weight and

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id.* at § 10.404(a).

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

[9] A.M.A., *Guides* 494-531.

[10] *Supra* note 3.

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

[12] 5 U.S.C. § 8123(a); *A.R.*, Docket No. 18-0632 (issued October 19, 2018).

rationale."[13] Where OWCP has referred the case to an IME to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well-reasoned and based upon a proper factual background, must be given special weight.[14]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish more than three percent permanent impairment of the right upper extremity, for which he previously received schedule award compensation.

OWCP properly determined that a conflict arose between Dr. Weiss, an attending physician, and Dr. Slutsky, a DMA, regarding the extent of appellant's permanent impairment of the right upper extremity. It referred him to Dr. Didizian, a Board-certified orthopedic surgeon, for an impartial medical examination.

Dr. Didizian evaluated appellant on August 26, 2014 and measured range of right elbow motion as 3 to 140 degrees. The Board notes that this does not constitute a ratable impairment due to range of motion under the A.M.A., *Guides* according to Table 15-33 on page 474, and thus the right elbow impairment was properly rated using the diagnosis-based method pursuant to FECA Bulletin No. 17-06.

On examination, Dr. Didizian found no evidence of cubital tunnel syndrome. He further found no instability, synovitis, or tenosynovitis of the wrists, with minimal atrophy at the right abductor pollicis brevis causing no loss of strength. Dr. Didizian opined that appellant had three percent permanent impairment of the right upper extremity due to carpal tunnel syndrome using Table 15-23 of the A.M.A., *Guides*. He applied a grade modifier of one for conduction delay, and grade modifier of one for minimal physical findings, noting that the functional scale was normal. Dr. Didizian further determined that appellant had one percent permanent impairment due to olecranon bursitis with no objective findings, for four percent permanent impairment of the right upper extremity.

In an August 14, 2016 supplemental report, Dr. Didizian explained that in rating appellant's carpal tunnel syndrome under Table 15-23, he had applied a grade modifier of 1 due to positive electrodiagnostic testing, a grade modifier of 1 for appellant's history of mild symptoms, and grade modifiers of zero for lack of a functional deficiency and for physical findings. He determined that he should have added the grade modifiers and divided by two, and thus modified his impairment rating for carpal tunnel syndrome to find one percent permanent impairment of the right upper extremity. On February 17, 2017 Dr. Didizian identified the right elbow impairment as class 1 olecranon bursitis using Table 15-4. He applied grade modifiers of one for clinical studies and functional history, and a grade modifier of zero for physical examination findings, and adjusted the impairment rating one place down from the default value

[13] *C.H.*, Docket No. 18-1065 (issued November 29, 2018).

[14] *W.M.*, Docket No. 18-0957 (issued October 15, 2018).

to find two percent permanent impairment.[15] Dr. Didizian combined the impairment ratings for olecranon bursitis and carpal tunnel syndrome and concluded that appellant had three percent permanent impairment of the right upper extremity. The Board finds that OWCP properly accorded the special weight of the evidence to the well-reasoned report of Dr. Didizian.[16] Dr. Didizian accurately summarized the relevant medical evidence, provided detailed findings on examination, and reached conclusions about appellant's condition which comported with his findings.[17] As his report is detailed, well rationalized and based on a proper factual background, his opinion is entitled to the special weight accorded an IME.[18]

On March 24, 2017 Dr. Harris, a DMA, reviewed Dr. Didizian's August 26, 2014 report, rather than his supplemental reports, and concluded that appellant had four percent permanent impairment of the right upper extremity. It is the IME, however, who must resolve the conflict on the degree of permanent impairment in accordance with the A.M.A., *Guides*.[19]

In a report dated August 21, 2017, Dr. Weiss opined that appellant had five percent impairment due to carpal tunnel syndrome, noting that he disagreed with Dr. Didizian's application of grade modifiers. He further found two percent permanent impairment due to right elbow olecranon bursitis, for a total right upper extremity impairment rating of eight percent. Dr. Weiss, however, based his impairment rating on a 2012 examination and thus his opinion is of diminished probative value.[20] Moreover, the Board has held that reports from a physician who was on one side of a medical conflict resolved by an IME are generally insufficient to overcome the special weight accorded the report of the IME or create a new conflict.[21]

On appeal counsel asserts that OWCP should have referred appellant to a new IME after Dr. Didizian failed to clarify his opinion. Dr. Didizian, however, as requested by OWCP, clarified his rating of appellant's carpal tunnel syndrome in an August 14, 2016 report and his impairment rating for olecranon bursitis in a February 17, 2017 report. Counsel further maintains that his opinion is not rationalized and thus insufficient to resolve the conflict in medical opinion. As

[15] Utilizing the net adjustment formula discussed above, (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), or (1-1) + (0-1) + (1-1) = -1, yielded a net adjustment of negative one.

[16] *A.R.*, Docket No. 18-0632 (issued October 19, 2018).

[17] *Id*.

[18] *See W.B.*, Docket No. 17-1698 (issued May 16, 2018).

[19] OWCP's procedures provide that, if a case has been referred to an IME to resolve a conflict regarding permanent impairment, it is not necessary to route the file to a DMA as long as the IME explains his impairment rating and cites the appropriate tables and the A.M.A., *Guides.* The DMA should not resolve the conflict in medical opinion. *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability* Claims, Chapter 2.808.6(g) (March 2017).

[20] A report not based on reasonably current findings is of little probative value. *See E.W.*, Docket No. 17-0333 (issued July 27, 2017).

[21] *D.M.*, Docket No. 17-1992 (issued September 12, 2018); *S.F.*, Docket No. 17-1427 (issued May 16, 2018).

discussed, however, Dr. Didizian's opinion is rationalized and based on a proper factual and medical background, and thus is entitled to the special weight of the evidence.[22]

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 his burden of proof to establish more than three percent permanent impairment of the right upper extremity, for which he previously received schedule award compensation.

ORDER

IT IS HEREBY ORDERED THAT the February 2, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 1, 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

[22] *W.B.*, Docket No. 17-1698 (issued May 16, 2018).