United States Department of Labor
Employees' Compensation Appeals Board

B.W., Appellant	)	
and	)	**Docket No. 18-0901**
	)	**Issued: January 24, 2019**
DEPARTMENT OF VETERANS AFFAIRS, JESSE BROWN VETERANS ADMINISTRATION MEDICAL CENTER, Chicago, IL, Employer	)	

Appearances:
Stephanie N. Leet, 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
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On March 29, 2018 appellant, through counsel, filed a timely appeal from a February 27, 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 established more than three percent permanent impairment of each upper extremity, for which she previously received schedule award compensation.

FACTUAL HISTORY

On January 21, 2010 appellant, then a 54-year-old program support clerk, filed a traumatic injury claim (Form CA-1) alleging that on that day she experienced pain in both wrists, right hand, shoulder, arm, and neck as a result of repetitive typing while in the performance of duty.

In a November 1, 2011 development letter, OWCP informed appellant that initially her claim appeared to be for a minor injury that resulted in minimal or no lost time from work and therefore had been administratively handled. However, as expenses had exceeded $1,500.00, it would now be adjudicating her claim. OWCP subsequently accepted the claim for bilateral carpal tunnel syndrome, bilateral radial styloid tenosynovitis, and cervical strain.

On December 3, 2014 appellant filed a claim for a schedule award (Form CA-7).

OWCP, in another development letter dated December 5, 2014, requested that appellant submit a medical report from her physician assessing her permanent impairment based on the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[3] and establishing the date on which she reached maximum medical improvement (MMI).

In a December 31, 2014 medical report, Dr. Eugene P. Lopez, a Board-certified orthopedic surgeon, provided findings on physical examination and an impression that appellant had work-related bilateral carpal tunnel syndrome, de Quervain's tenosynovitis, and cervical strain. He advised that she had reached MMI. Dr. Lopez ordered a functional capacity evaluation (FCE) to determine appellant's work restrictions and impairment under the A.M.A., *Guides*.

On January 20, 2015 appellant underwent an FCE by physical therapist, Patricia Canar. In Ms. Canar's report dated January 26, 2015, she related that appellant could perform employment duties at the light physical demand level.

OWCP referred the case to Dr. David H. Garelick, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA). It requested that he review the case record, including Ms. Canar's January 26, 2015 FCE report, and provide an opinion on the degree of appellant's permanent impairment under the standards of the sixth edition of the A.M.A., *Guides*.

In a February 23, 2015 report, Dr. Garelick noted that he had reviewed medical records, including Dr. Lopez' notes and Ms. Canar's January 20, 2015 FCE report. He noted that the FCE results and appellant's subjective complaints were not necessarily a reliable representation of her condition based on inconsistencies noted during the FCE. Thus, Dr. Garelick advised that there was no objective basis for finding upper extremity permanent impairment based on de Quervain's

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

tenosynovitis. He concluded that appellant had two percent permanent impairment of each upper extremity for mild carpal tunnel syndrome under Table 15-23, page 449 of the A.M.A., *Guides*. Dr. Garelick determined that she had reached MMI as of December 31, 2014, the date of Dr. Lopez' examination.

By decision dated March 10, 2015, OWCP granted appellant a schedule award for two percent permanent impairment of each upper extremity. The award ran for the period December 31, 2014 to March 28, 2015, for a total of 12.48 weeks of compensation, and was based on Dr. Garelick's February 23, 2015 opinion.

In an appeal request form and letter received by OWCP on September 16, 2015, appellant, through counsel, requested reconsideration and submitted additional medical evidence. In a June 1, 2015 report, Dr. Neil Allen, a Board-certified internist and neurologist, related a history of the accepted January 21, 2010 employment injuries and discussed his examination findings. He utilized the diagnosis-based impairment (DBI) method to determine impairment for de Quervain's tenosynovitis and found that appellant had a combined 32 percent permanent impairment of the upper extremity due to motor and sensory deficits under the sixth edition of the A.M.A., *Guides*. Dr. Allen noted that, in accordance with pages 419 and 448 of the A.M.A., *Guides*, he did not determine impairment due to the condition of bilateral carpal tunnel syndrome because, although she underwent electrodiagnostic testing, he was unable to obtain a report indicating the findings and conclusions of the examination.

On January 27, 2016 OWCP referred appellant's case to Dr. Michael M. Katz, a Board-certified internist serving as an OWCP DMA, for review. In a report dated January 27, 2016, Dr. Katz noted that Dr. Allen had not specified whether his impairment ratings were applicable to one extremity or both extremities. He opined that, Dr. Allen's report could not be considered probative for the purpose of recommending a schedule award for multiple reasons. Dr. Katz noted that brachial neuritis/radiculitis was not an accepted condition of appellant's claim and cervical sprain would not be expected to produce the findings reported by Dr. Allen. Given that the medical file contained findings from electrodiagnostic testing performed on February 11, 2010, the appropriate method to rate carpal tunnel syndrome was solely by Table 15-23. Dr. Allen's findings were in direct conflict with this electrodiagnostic report, which demonstrated only mild-to-moderate carpal tunnel syndrome bilaterally with no evidence for radicular/spinal nerve impairment.

By decision dated February 2, 2016, OWCP denied modification of its March 10, 2015 decision. It found that the weight of the medical evidence rested with Dr. Katz' January 27, 2016 opinion and established that appellant had no more than two percent permanent impairment of each upper extremity.

On December 20, 2016 counsel requested reconsideration and submitted additional medical evidence, including Dr. Allen's February 19, 2016 addendum to his June 1, 2015 report. In this addendum report, Dr. Allen disagreed with Dr. Katz' assessment of his findings. He maintained that his June 1, 2015 report indicated that sensory and motor deficits were bilateral and explained the reason why he could not rate appellant's impairment due to her accepted bilateral carpal tunnel syndrome. Dr. Allen cited medical literature and referenced medical reports in the record in support of his cervical spine findings. He concluded that Dr. Katz' analysis and opinions lacked scientific evidence and support within the literature.

On March 29, 2017 OWCP referred appellant's case to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as an OWCP DMA. On March 31, 2017 Dr. Harris opined that she had two percent permanent impairment of each upper extremity for residual problems with mild carpal tunnel syndrome and status post carpal tunnel release. He assigned a grade modifier 1 for clinical studies under Table 15-23, page 449 for each upper extremity. Dr. Harris advised that the two percent bilateral upper extremity permanent impairment rating was the sole impairment resulting from the accepted January 21, 2010 work injury. He determined that appellant had reached MMI on June 1, 2015, the date of Dr. Allen's examination. Dr. Harris noted that contrary to Dr. Allen's finding that he was unable to rate her impairment for bilateral carpal tunnel syndrome because no electrodiagnostic studies were available, he reviewed electrodiagnostic studies performed on February 11, 2010, which were consistent with bilateral carpal tunnel syndrome and a basis for his impairment ratings.

By decision dated April 4, 2017, OWCP denied modification of its February 2, 2016 decision. It accorded the weight of the medical evidence to Dr. Harris' March 31, 2017 opinion.

On May 30, 2017 counsel requested reconsideration.

On June 12, 2017 OWCP again referred appellant's case to Dr. Harris. In a June 13, 2017 report, Dr. Harris noted that Dr. Allen's examination documented that she had significant problems with bilateral C5, C6, C7, and C8 radiculopathy. He noted that the accepted condition was cervical strain and prior electrodiagnostic studies had not demonstrated evidence of cervical radiculopathy. In addition, no magnetic resonance imaging scans documented cervical pathology which would account for appellant's ongoing cervical radiculopathy. Based on his findings, Dr. Harris recommended that she be seen by another physician for evaluation, including documentation of her subjective complaints, objective findings, and impairment rating based on the sixth edition of the A.M.A., *Guides* regarding her problems with residual carpal tunnel syndrome and cervical spine injury. Thus, he noted that he could not comment on any change in appellant's impairment based on his recommendation that she undergo further evaluation.

On July 17, 2017, QTC Medical Services, OWCP's scheduler, referred appellant, together with the medical record, statement of accepted facts (SOAF), and a set of questions, to Dr. Allan M. Brecher, a Board-certified orthopedic surgeon, for a second opinion regarding the extent of her bilateral upper extremity permanent impairment.

In an August 29, 2017 report, Dr. Brecher discussed examination findings. He noted that appellant's surgery for de Quervain's tenosynovitis and carpal tunnel syndrome was scheduled to be performed that month, but it had been delayed. Dr. Brecher therefore advised that she had not reached MMI for her upper extremities and that he could not rate her impairment based on the sixth edition of the A.M.A., *Guides*. He related that appellant would need to be checked several months postsurgery and completion of postoperative therapy. Regarding her cervical sprain, Dr. Brecher related that it should have resolved based on time. He indicated that appellant may have underlying problems in her neck, but he had an incomplete workup and there was certainly no evidence other than the carpal tunnel syndrome and de Quervain's tenosynovitis that showed any impairment in the upper extremities. Dr. Brecher further indicated that he could not address her adhesive capsulitis as it was not an accepted condition.

By decision dated September 29, 2017, OWCP denied modification of its April 4, 2017 decision, finding that Dr. Brecher's report indicated that appellant had not reached MMI and, thus, he could not render an impairment rating.

In a letter received on November 14, 2017 by OWCP, appellant, through counsel, requested reconsideration. Counsel indicated that appellant was not undergoing surgery at that time, but that her physicians found that she had reached MMI.

Appellant submitted an October 13, 2017 report from Dr. Kevin W. Chen, a Board-certified orthopedic surgeon. Dr. Chen noted that she had chosen to not undergo surgery for her bilateral carpal tunnel syndrome. He further noted that appellant had reached MMI.

On February 12, 2018 OWCP again referred appellant's case to Dr. Harris to review the SOAF and the case record, including Dr. Brecher's August 29, 2017 report and Dr. Chen's October 13, 2017 report, and provide an opinion on her permanent impairment in accordance with the sixth edition of the A.M.A., *Guides*.

In a February 13, 2018 report, Dr. Harris noted the accepted diagnoses of bilateral carpal tunnel syndrome and bilateral de Quervain's tenosynovitis.[4] He utilized the DBI method and found that appellant had two percent permanent impairment of the right upper extremity for residual problems with mild carpal tunnel syndrome (grade modifier 1C, Table 15-23, page 449). Dr. Harris noted that the sixth edition of the A.M.A., *Guides* did not allow for impairment ratings to be calculated by the range of motion (ROM) method for a carpal tunnel syndrome diagnosis. He determined that appellant had one percent permanent impairment of the right upper extremity due to residual problems with de Quervain's tenosynovitis ([diagnosed condition] (CDX) 1C, Table 15-3, page 395). Dr. Harris further related that there was insufficient information contained in the case file to calculate an impairment rating utilizing the ROM method. He explained that Dr. Brecher's report did not contain the complete ROM measurements for the right wrist. Dr. Harris indicated that he calculated impairment for the entire extremity, including both accepted and nonaccepted conditions in accordance with "FECA Transmittal 17-02." He found that appellant had two percent permanent impairment of the left upper extremity for residual problems with mild carpal tunnel syndrome (grade modifier 1C, Table 15-23, page 449). Dr. Harris also found that she had one percent impairment of the right upper extremity due to residual problems with de Quervain's tenosynovitis ([diagnosed condition] (CDX) 1C, Table 15-3, page 395). Utilizing the Combined Values Chart, he combined the two percent upper extremity impairment rating and one percent impairment upper extremity rating, which yielded three percent permanent impairment of each upper extremity.

By decision dated February 27, 2018, OWCP granted modification of its prior decision as it found that appellant had an additional one percent permanent impairment of each upper

[4] The Board notes that in his February 13, 2018 report, Dr. Harris indicated that appellant's diagnosis of de Quervain's tenosynovitis was not a condition accepted by OWCP. The condition of de Quervain's disease is a painful tenosynovitis due to relative narrowness of the common tendon sheath of the abductor pollicis longus and the extensor pollicis brevis. The radial styloid process is the area at the distal end of the forearm connected to the hand. *See* DORLAND'S, Illustrated Medical Dictionary (30th ed. 2003) 531, 1865, 1565. The Board notes that radial styloid tenosynovitis, the condition accepted by OWCP as employment related, is also known as de Quervain's tenosynovitis. *S.S.*, Docket No. 14-211 (issued May 1, 2014).

extremity, totaling three percent permanent impairment, based on the opinions of Dr. Brecher and Dr. Harris.

In a separate decision dated February 27, 2018, OWCP granted appellant a schedule award for an additional one percent permanent impairment of each upper extremity, totaling three percent permanent impairment. The schedule award ran for the period August 29 to October 11, 2017, for a total of 6.24 weeks of compensation.

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, functions, and organs of the body. FECA, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[7] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[8] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[9] 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.[10]

The sixth edition of the A.M.A., *Guides* provides a DBI method of evaluation utilizing the World Health Organization's International Classification of Functioning (ICF), Disability and Health.[11] The sixth edition requires identifying the impairment class of diagnosis (CDX) condition, which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE), and clinical studies (GMCS).[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[14] In

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

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

[8] *Id.*

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (March 2017); Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (March 2017).

[10] *Isidoro Rivera*, 12 ECAB 348 (1961).

[11] *Supra* note 3, page 3, section 1.3, The ICF, Disability and Health: A Contemporary Model of Disablement.

[12] *Supra* note 3 at 411.

[13] *Id.*

[14] *Id.* at 449.

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 modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating value may be modified up or down based on functional scale, an assessment of impact on daily living activities (*Quick*DASH-Disabilities of the Arm, Shoulder, and Hand).[15]

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

> "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.*"[16] (Emphasis in the original.)
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> The Bulletin further advises:
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> "If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* allow for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the claims examiner (CE).
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> "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 necessary to complete the rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence.
>
> "However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence. Upon receipt of such a report, and if the impairment evaluation was provided from the claimant's physician, the CE should write to the claimant advising of the medical evidence necessary to complete the impairment assessment and provide 30 days for submission. Any evidence received in response should then be routed back to the DMA for a final determination. Should no evidence be received within 30 days of the date of the CE's letter, the CE should proceed with a referral for a second opinion medical evaluation to obtain the medical evidence necessary to complete the rating. After receipt of the second opinion physician's evaluation, the CE should route that report to the DMA for a final determination."[17]

[15] *Id.* at 448-49.

[16] FECA Bulletin No. 17-06 (issued May 8, 2017); *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

[17] *Id.*

ANALYSIS

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

OWCP accepted appellant's claim for bilateral carpal tunnel syndrome, bilateral radial styloid tenosynovitis, and cervical strain. On March 10, 2015 it issued a schedule award for two percent permanent impairment of the right upper extremity and two percent permanent impairment of the left upper extremity for mild carpal tunnel syndrome under Table 15-23 of the A.M.A., *Guides*. The Board finds that there is no medical evidence of record that appellant has more than a two percent permanent impairment of her bilateral wrists due to carpal tunnel syndrome. The Board also notes that regarding the accepted condition of cervical strain, there is no evidence of record that this condition has caused a permanent impairment, pursuant to the A.M.A., *Guides.*

On February 27, 2018 OWCP granted appellant a schedule award for an additional one percent impairment of each upper extremity due to her accepted condition of de Quervain's tenosynovitis. The Board finds that this rating is not in posture for decision.

In his February 13, 2018 report, Dr. Harris, OWCP's DMA, opined that the DBI method was appropriate for bilateral de Quervain's tenosynovitis conditions, rather than the ROM approach. He also noted that there was insufficient information contained in the case file to calculate an impairment rating utilizing the ROM method. Dr. Harris related that Dr. Brecher's report did not contain the complete measurements for the right wrist. Regarding impairment due to de Quervain's tenosynovitis, he used Table 15-3 on page 395 and assigned a grade modifier 1 for clinical studies for residual problems with this condition, which represented one percent impairment of the right upper extremity.

The Board notes that a rating based upon appellant's loss of ROM of her upper extremities for de Quervain's tenosynovitis is allowed (by asterisk) pursuant to Table 15-3 of the A.M.A., *Guides*.[18] The Board therefore finds that, pursuant to FECA Bulletin No. 17-06, if the medical evidence of record was insufficient for OWCP's medical adviser to render a rating using the ROM or DBI method, he should have advised as to the medical evidence necessary to complete the rating.[19]

Dr. Harris was required to independently calculate appellant's impairment using both the DBI and ROM methods and identify the higher rating for the claim's examiner.[20] He indicated that the record did not contain adequate ROM findings to conduct a permanent impairment rating under the ROM method. As noted above, FECA Bulletin No. 17-06 provides detailed instructions for obtaining sufficient evidence to conduct a complete permanent impairment evaluation, including referral for a second opinion evaluation in some cases. However, such instructions were

[18] A.M.A., *Guides* 395, Table 15-3.

[19] *Supra* note 16.

[20] *Id.*

not carried out in the present case and therefore this case requires further development of the medical evidence in accordance with FECA Bulletin No. 17-06.[21]

This case will therefore be remanded for application of the new OWCP procedures found in FECA Bulletin No. 17-06 following the referral of appellant to a second opinion examination at which time appropriate physical findings can be assessed. After this and any other such development of the medical evidence as 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 February 27, 2018 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision of the Board.

Issued: January 24, 2019
Washington, DC

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

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

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

[21] *See A.G.*, Docket No. 18-1314 (issued January 11, 2019).