United States Department of Labor
Employees' Compensation Appeals Board

L.G., Appellant	)	
and	)	**Docket No. 18-0519**
	)	**Issued: March 8, 2019**
DEPARTMENT OF HOMELAND SECURITY, TRANSPORTATION SECURITY ADMINISTRATION, Arlington, 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:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 17, 2018 appellant, through counsel, filed a timely appeal from an August 15, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the

[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.

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 the case.[3]

ISSUES

The issues are: (1) whether appellant has met her burden of proof to establish more than 20 percent permanent impairment of her right lower extremity, for which she previously received a schedule award; and (2) whether she has met her burden of proof to establish more than 3 percent permanent impairment of her right upper extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On February 13, 2013 appellant, then a 42-year-old transportation security specialist, filed a traumatic injury claim (Form CA-1) alleging several injuries that she attributed to a February 8, 2013 slip and fall on a wet floor in the lobby while in the performance of duty. She stopped work on February 11, 2013. OWCP initially accepted the claim for right hip contusion, right medial meniscus tear, right knee effusion, and right wrist intersection syndrome. It later expanded acceptance of the claim to include right hip bursitis and right knee iliotibial band syndrome.[4] Appellant underwent OWCP-authorized right knee arthroscopic partial medial menisectomy on April 18, 2013 and release of second extensor compartment of right forearm/wrist on June 6, 2013. She eventually returned to work.

In a July 25, 2014 report, Dr. David P. Sokolow, a Board-certified orthopedic surgeon, opined, in pertinent part, that appellant's right wrist carpal tunnel syndrome was a direct result of the February 8, 2013 employment injury. In an August 8, 2014 report, Dr. Ali R. Hashemi, a Board-certified orthopedic surgeon, also opined that appellant's fall and her injury caused tenosynovitis of her right wrist, and hand, and carpal tunnel syndrome secondary to swelling and pain and compensation. He explained that the carpal tunnel syndrome was a result of the inflammation from the fall and the stiffness that she developed from her tendinitis.

In a September 9, 2014 report, Dr. Chester DiLallo, a Board-certified orthopedic surgeon and second opinion physician, reported appellant's history of injury, reviewed the medical record and statement of accepted facts (SOAF), and presented examination findings. In pertinent part, he

[2] 5 U.S.C. § 8101 *et seq.*

[3] The Board notes that following the August 15, 2017 decision, OWCP received additional evidence. However, the *Board's Rules of Procedure* provides: "The Board's review of a case is limited to evidence 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.*

[4] OWCP assigned the present claim File No. xxxxxx302. Under OWCP File No. xxxxxx307, OWCP accepted right knee contusion and right knee medial meniscus tear for a June 10, 2006 employment injury. By decision dated January 14, 2010, it granted appellant a schedule award for 20 percent permanent impairment of the right lower extremity under OWCP File No. xxxxxx307. OWCP File Nos. xxxxxx302 and xxxxxx307 have been administratively combined, with the latter serving as the master file.

indicated that in addition to the accepted condition of the right wrist, complex regional pain syndrome (CRPS) should be added as an accepted diagnosis, but he related that there was no evidence of carpal tunnel syndrome.[5] Dr. DiLallo reported that he could not confirm the diagnosis of carpal tunnel syndrome as the nerve conduction study had not been provided to him.

In a February 18, 2015 report, Dr. Sokolow related that appellant had class 2 CRPS which resulted in 25 percent right upper extremity impairment under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[6]

On February 26, 2015 appellant underwent right carpal tunnel release surgery.[7] She filed a claim for a schedule award (Form CA-7) on April 7, 2016.

In an April 16, 2016 report, Dr. Joshua B. Macht, an internist, noted the history of the February 8, 2013 employment injury and her medical history. He also noted appellant's symptoms and provided physical examination findings, including range of motion (ROM) findings for the right hip, right knee, and right wrist. Dr. Macht noted that all of the ROM findings were repeated at least three times for accuracy and to meet the validity criteria according to the sixth edition of the A.M.A., *Guides*. He diagnosed traumatic injury to right hip with chronic bursitis, postoperative state of right knee, status post partial medial meniscectomy; and traumatic injury to right wrist and hand with intersection syndrome of the wrist and carpal tunnel syndrome. Dr. Macht opined that appellant had reached maximum medical improvement (MMI) and that all the impairments calculated were causally related to the February 8, 2013 employment injury.

For the right lower extremity impairment, Dr. Macht used the diagnosed-based impairment (DBI) rating method. He calculated two percent impairment for the right knee meniscal injury under Table 16-3 and two percent impairment for the right hip bursitis under Table 16-4, for a total right lower extremity impairment of four percent.

For the diagnosis of intersection syndrome of the right wrist, Dr. Macht used the ROM method to calculate permanent impairment. He determined that appellant had a total combined right upper extremity impairment of nine percent. Under Table 15-32, Dr. Macht calculated three percent impairment for 50 degrees of wrist flexion. Under Table 15-23, he also calculated six percent impairment for right carpal tunnel syndrome. Dr. Macht noted that appellant could not be assigned impairment for CRPS as she did not meet the diagnostic criteria under Table 15-25.

On August 9, 2016 OWCP prepared an August 9, 2016 SOAF[8] and forwarded the case record, including Dr. Macht's impairment rating report, to its district medical adviser (DMA),

[5] Dr. DiLallo noted that his examination of appellant revealed no positive Tinel's sign at the wrist or over the superficial branch of the radial nerve.

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

[7] OWCP appeared to have authorized and paid for the right carpal tunnel syndrome surgery. However, there is no evidence that OWCP accepted that right carpal tunnel syndrome was work related.

[8] The SOAF did not indicate that appellant underwent a right carpal tunnel release on February 26, 2015.

Dr. Herbert White, Jr., an occupational and environmental specialist, to determine appellant's permanent impairment of the right lower and upper extremities.

In an August 14, 2016 report, Dr. White reviewed the SOAF and the medical record.[9] He found that appellant reached MMI on April 16, 2016, the date of Dr. Macht's impairment rating. Dr. White also used Dr. Macht's examination findings to rate appellant's permanent impairment under the A.M.A., *Guides.* For the right lower extremity, he concurred with Dr. Macht's total impairment of four percent. For the right hip, Dr. White found a class 1 for contusion under Table 16-4, page 512. He found grade modifier functional history (GMFH) 2 under Table 16-6; grade modifier physical examination (GMPE) 1 under Table 16-7. A grade modifier clinical studies (GMCS) was excluded under Table 16-8. Applying the net adjustment formula, Dr. White found a net adjustment of 1, which moved the default impairment at class 1 grade C to grade D, which resulted in an impairment rating of two percent. For the right knee, he found a partial medial meniscectomy repair was class 1 diagnosis under Table 16-3. Dr. White excluded GMFH, citing to page 516 A.M.A., *Guides* as it was already used for the highest rated impairment in the extremity. He also excluded GMCS, citing to page 519 A.M.A., *Guides* as there was none at MMI. He found GMPE grade 1 under Table 16-7, page 517. A net adjustment of zero resulted from the net adjustment formula calculation. Accordingly, Dr. White found that appellant had class 1 grade C impairment of two percent under Table 16-3. Using the Combined Values Chart, he combined the impairment ratings for right hip and right knee and found four percent total right lower extremity permanent impairment. Dr. White stated that since appellant had previously been awarded a right lower extremity impairment rating of 20 percent, she was not entitled to a schedule award for an additional impairment as the current right lower extremity rating of 4 percent was less than that previously awarded.

For the right wrist, Dr. White reported that the DBI under Table 15-3, page 395, was class 1 which included intersection syndrome.[10] No calculations or impairment rating was provided. Utilizing the ROM method, Dr. White concurred with Dr. Macht's impairment rating of three percent. Under Table 15-32, page 473, he found a total of three percent upper extremity permanent impairment. Dr. White found that flexion 50 degrees equaled three percent upper extremity impairment; extension 60 degrees equaled zero percent upper extremity impairment; radial deviation 20 degrees equaled zero percent upper extremity impairment; and ulnar deviation 30 degrees equaled zero percent upper extremity impairment. He noted that under Table 15-35, page 477, the ROM grade modifier was grade 1 as it was equivalent to a GMPE score of 1. The GMFH was grade 4 due to *Quick*DASH score of 86. However, it was excluded as it was 2 or greater than the GMPE and determined to be unreliable. Dr. White opined that appellant's final impairment rating for the right upper extremity was three percent for right intersection syndrome, the only accepted condition.

Dr. White noted that Dr. Macht had rated the right carpal tunnel syndrome, but indicated that OWCP had not accepted this condition. He found five percent right upper extremity impairment for the carpal tunnel syndrome, in case it became an accepted condition. Dr. White

[9] Dr. White noted that appellant had a right carpal tunnel release on February 26, 2015. He also reported his interpretation of the objective testing of the right wrist.

[10] The maximum impairment for class 1 sprain/strain is two percent with a default impairment of one percent.

also indicated reasons why his rating for right carpal tunnel syndrome differed from Dr. Macht's rating of six percent. He indicated that, if the right carpal tunnel condition became an accepted condition, then appellant's combined right upper extremity rating would be eight percent.

By decision dated November 7, 2016, OWCP granted appellant a schedule award for three percent permanent impairment of the right upper extremity. No additional award was provided for the right lower extremity. The award covered a period of 9.36 weeks from April 16 to June 20, 2016. The weight of the medical evidence was accorded to the DMA's report of August 14, 2016.

On November 11, 2016 appellant, through counsel, requested a hearing before a representative of OWCP's Branch of Hearings and Review.

OWCP received a November 16, 2016 electromyography (EMG) report.

A telephonic hearing was held on June 8, 2017.

By decision dated August 15, 2017, an OWCP hearing representative affirmed OWCP's November 7, 2016 decision.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA,[11] and its implementing federal regulations,[12] 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.[13] For decisions issued after May 1, 2009, the sixth edition is used to calculate schedule awards.[14]

In addressing lower extremity impairments, the sixth edition requires identification of the impairment class of diagnosis (CDX) condition, which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[15] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of

[11] 5 U.S.C. § 8107.

[12] 20 C.F.R. § 10.404.

[13] *Id.* at § 10.404(a).

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

[15] A.M.A., *Guides* 521.

modifier scores.[16] Section 16.2a of the A.M.A., *Guides*, provides that, if the class selected is defined by physical examination findings or clinical studies results, these same findings may not be used as grade modifiers to adjust the rating.[17]

It is well established that benefits payable under 5 U.S.C. § 8107(c) are reduced by the period of compensation paid under the schedule for an earlier injury if: (1) compensation in both cases is for impairment of the same member or function or different parts of the same member or function; and (2) the latter impairment in whole or in part would duplicate the compensation payable for the preexisting impairment.[18]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[19]

ANALYSIS -- ISSUE 1

The Board finds that the case is not in posture for decision as to whether appellant has more than 20 percent permanent impairment of the right lower extremity, for which she previously received a schedule award.

To determine the permanent impairment of appellant's right knee, both Dr. Macht and the DMA identified the diagnosis as CDX one partial medial meniscectomy repair under Table 16-3 on page 509 of the A.M.A., *Guides*, which yielded a default (C) value of two percent. Both physicians assigned grade modifier 1 for physical examination and excluded grade modifiers for functional history and clinical studies. The net adjustment (0) resulted in no change from the default value of two percent (grade C).[20] As appellant had previously received a schedule award for 20 percent right lower extremity permanent impairment under OWCP File No. xxxxxx307, she would not be entitled to an additional schedule award as this claim only yielded two percent right lower extremity permanent impairment.[21]

For the right hip condition, however, both Dr. Macht and the DMA identified the diagnosis as CDX one bursitis contusion under Table 16-4 on page 512 of the A.M.A., *Guides*, which yielded a default (C) value of one percent. Both physicians assigned grade modifiers for functional history

[16] *Id.* at 4, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement; *W.S.*, Docket No. 16-1111 (issued March 14, 2017).

[17] *Id.* at 500.

[18] *See J.K.*, Docket No. 16-1361 (issued April 18, 2017); *T.S.*, Docket No. 09-1308 (issued December 22, 2009); 20 C.F.R. § 10.404(d).

[19] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (March 2017).

[20] Net Adjustment (0) (GMPE 1-CDX 1). *See* Section 16.3d, A.M.A., *Guides* 518-21 (6th ed. 2009).

[21] *See supra* note 19.

(GMFH 2) and physical examination (GMPE 1), and the net adjustment (1) resulted in a change from the default value of one percent (grade C) to two percent (grade D).[22]

The medical evidence of record therefore supports that appellant has permanent impairment of the right lower extremity due to the accepted hip conditions. The Board finds that OWCP did not explain why appellant's current impairment rating for the right hip duplicated his previous schedule award compensation, in particular the rating issued for his right knee. The Board has explained that simply comparing the prior percentage of impairment awarded to the current impairment for the same member is not always sufficient.[23] The issue is not whether the current impairment rating is greater than the prior impairment ratings, but whether it duplicates in whole or in part the prior impairment rating.[24] Accordingly, the case will be remanded to OWCP to determine whether the impairment rating duplicates, in whole or in part, appellant's prior award. After this and any other further development as deemed necessary, it shall issue a *de novo* decision.

LEGAL PRECEDENT -- ISSUE 2

Under the sixth edition, for upper extremity impairments the evaluator identifies the impairment for the class of diagnosis condition, which is then adjusted by grade modifiers based on functional history, physical examination, and clinical studies. The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX). The grade modifiers are used on the net adjustment formula described above to calculate a net adjustment. The final impairment grade is determined by adjusting the grade up or down the default value C, by the calculated net adjustment.[25]

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:

> "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.)[26]

The Bulletin further advises:

[22] Net Adjustment (1) (GMFH 2-CDX 1) + (GMPE 1-CDX 1). *See* Section 16.3d, A.M.A., *Guides* 518-21 (6th ed. 2009).

[23] *See T.S.*, Docket No. 16-1406 (issued August 9, 2017).

[24] *Id.*

[25] *Supra* note 22 at 387.

[26] FECA Bulletin 17-06 (issued May 8, 2017). *See also D.F.*, Docket No. 17-1474 (issued January 23, 2018); *D.B.*, Docket No. 17-1526 (issued April 6, 2018).

> "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."[27]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text. 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 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).[28]

ANALYSIS -- ISSUE 2

The Board also finds that the case is not in posture for decision as to whether appellant has more than three percent permanent impairment of the right upper extremity, for which she previously received a schedule award.

The Board finds that OWCP has not properly developed the issue of whether appellant sustained a right wrist carpal tunnel syndrome or CRPS causally related to the accepted employment injury. While appellant's treating physicians, Dr. Sokolow and Dr. Hashemi related that appellant developed right wrist carpal tunnel syndrome causally related to her February 8, 2013 employment injury, OWCP's second opinion physician Dr. DiLallo related that he could not confirm the diagnosis as appellant's nerve conduction velocity study had not been forwarded to him. Dr. Sokolow also related that complex regional pain syndrome should be added as an accepted condition.

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter.[29] While the claimant has the responsibility to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence. It has the obligation to see that justice is done.[30] Accordingly, once OWCP undertakes to develop the medical evidence further, it has the responsibility to do so in a manner that will resolve the relevant issues in the case.[31]

The complete case record, including diagnostic test results, shall be forwarded, along with an updated SOAF, to Dr. DiLallo for a supplemental report in which he addresses whether appellant's right carpal tunnel condition and complex regional pain syndrome are causally related

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[27] *Id.*

[28] *See B.W.*, Docket No. 18-0901 (issued January 24, 2019).

[29] *See T.C.*, Docket No. 17-1906 (issued May 25, 2018); *see also B.A.*, Docket No. 17-1360 (issued January 10, 2018); *R.M.*, Docket No. 16-0147 (issued June 17, 2016); *Melvin James*, 55 ECAB 406 (2004).

[30] *See B.A., id.*; *Richard E. Simpson*, 55 ECAB 490 (2004).

[31] *See B.A., supra* note 29; *R.M., supra* note 29; *Melvin James, supra* note 29.

to the February 8, 2013 employment injury. Dr. DiLallo should thereafter also address whether appellant has additional permanent impairment in accordance with the sixth edition of the A.M.A., *Guides* due to her accepted right wrist employment injury. Following this and any other such further development as deemed necessary, OWCP shall issue a *de novo* decision regarding appellant's schedule award claim for right upper extremity impairment in accordance with the A.M.A., *Guides* and FECA Bulletin No. 17-06.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the August 15, 2017 decision of Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: March 8, 2019
Washington, DC

Patricia H. Fitzgerald, Deputy 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