United States Department of Labor
Employees' Compensation Appeals Board

B.K., Appellant	)	
and	)	**Docket No. 19-0976**
	)	**Issued: December 15, 2020**
U.S. POSTAL SERVICE, POST OFFICE, Brooklyn, NY, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
CHRISTOPHER J. GODFREY, Deputy Chief Judge
JANICE B. ASKIN, Judge

JURISDICTION

On April 5, 2019 appellant filed a timely appeal from a February 13, 2019 decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has met his burden of proof to establish more than 11 percent permanent impairment of the left upper extremity, for which he has previously received schedule award compensation.

FACTUAL HISTORY

On January 29, 1982 appellant, then a 23-year-old carrier, filed a traumatic injury claim (Form CA-1) alleging that on January 26, 1982 he sustained a swollen left elbow and left arm

[1] 5 U.S.C. § 8101 *et seq.*

injury when he slipped and fell onto his left arm in the performance of duty.[2] OWCP accepted the claim for traumatic left elbow hemarthrosis, primary left elbow osteoarthritis, other specific left elbow joint derangements not elsewhere classified, and other complications from medical care.[3] On August 5, 1986 it authorized surgery to remove loose bodies from appellant's left elbow. A discharge note indicated that a procedure was performed for left elbow arthrotomy and removal of loose bodies on August 22, 1986.

On July 19, 2017 appellant filed a claim for a schedule award (Form CA-7).

On September 19, 2017 OWCP prepared a statement of accepted facts (SOAF) noting appellant's January 26, 1982 employment injury and an accepted condition of left elbow traumatic hemarthrosis. This SOAF indicated that OWCP File No. xxxxxx071 contained no medical reports.[4] It noted nonwork-related surgeries, including a left elbow surgery in 1980. OWCP also noted two other OWCP claims, including File No. xxxxxx138.

On September 27, 2017 OWCP referred appellant for a second opinion evaluation with Dr. Richard Semble, a Board-certified orthopedic surgeon, for an assessment of his left upper extremity permanent impairment. In an October 11, 2017 report, Dr. Semble noted that he had reviewed the SOAF and utilized the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[5] to find that appellant had six percent permanent impairment of the left upper extremity. He noted that he had used the diagnosis-based impairment (DBI) methodology for the diagnosis of left elbow sprain with bone chips by history.

In letters dated October 14 and 25, 2017, appellant noted that OWCP had advised that it was unable to locate the paper portion of the current claim. He asserted that he had sustained left wrist and hand conditions as the result of the January 26, 1982 employment injury, and that Dr. Semble should have considered those additional conditions in his permanent impairment evaluation. Appellant stated that Dr. Semble had refused to evaluate or examine his left hand and wrist since OWCP had only accepted a left elbow condition. He also noted that there were no x-rays, or neurophysiologic studies in the case record to properly evaluate his permanent impairment.

In a report dated October 27, 2017, Dr. James Michael Kipnis, a Board-certified orthopedic surgeon, noted that appellant was seen for a January 26, 1982 employment injury. Appellant

[2] OWCP assigned this claim File No. xxxxxx071. On February 22, 2018 it combined this file with OWCP File No. xxxxxx138, with the latter designated as the master file. Under OWCP File No. xxxxxx138, OWCP accepted the conditions of thoracolumbar sprain/strain, lumbosacral, left hip, and right hip derangement, left ankle sprain, bilateral shoulder pain, and left plantar fasciitis as due to an accepted November 26, 2010 employment injury.

[3] On September 17, 2012 appellant filed a claim for a recurrence alleging increased disability due to a consequential injury. In a letter dated October 1, 2012, OWCP advised him regarding the definition of a recurrence and informed him that his claim for a consequential left elbow condition was under development in OWCP File No. xxxxxx138.

[4] OWCP noted two OWCP referral physicians under OWCP File No. xxxxx138. A November 22, 2011 second opinion evaluation with Dr. Leon Sultan, a Board-certified orthopedic surgeon, and a March 4, 2012 impartial medical examination with Dr. Todd B. Soifer, a Board-certified orthopedic surgeon.

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

informed him that OWCP had no documents regarding his 1982 work injury as it had been archived in 2012, noting that he had injured his left elbow, hand, and wrist on January 26, 1982 when he tripped and fell on ice while delivering mail. He stated that he had undergone surgery in approximately 1989 to remove calcium deposits in his left elbow. Physical examination revealed negative cubital tunnel Tinel's sign, intact strength and flexion, lacking 10 degrees of terminal extension over radial head with pain, healed incision at left elbow postural lateral aspect, and intact grip strength. A left elbow x-ray interpretation revealed arthritis with osteophytes and joint space narrowing. Dr. Kipnis diagnosed left elbow arthritis, left hand first carpometacarpal joint primary osteoarthritis, left hand sprain, history of elbow surgery, and left cubital tunnel syndrome. He found appellant presented with post-traumatic elbow arthritis following a 1982 employment injury.

On December 8, 2017 OWCP referred the September 19, 2017 SOAF and medical record for review by an OWCP district medical adviser (DMA). In a December 12, 2017 report, the DMA, based upon a review of the SOAF and medical evidence provided, utilized the A.M.A., *Guides* to calculate that appellant had two percent left upper extremity permanent impairment using the DBI methodology for the diagnosis of left elbow contusion. Alternatively, he determined that appellant had zero percent permanent impairment using the range of motion methodology (ROM). Using Table 15-4, the DMA found a class of diagnosis (CDX) of 1 for his accepted contusion with residual symptoms and consistent objective findings.[6] He excluded the grade modifier for functional history (GMFH) based on the calculated *Quick*DASH score because it exceeded the grade modifier for physical evaluation (GMPE) by two or more grades.[7] The grade modifier for clinical studies (GMCS) was also excluded as appellant was at maximum medical improvement.[8] Using the net adjustment formula,[9] the DMA found that appellant had two percent permanent impairment of his left upper extremity. He noted that he was unable to explain why Dr. Semble found six percent left upper extremity permanent impairment while he found two percent left upper extremity permanent impairment. The DMA noted that the diagnostic grid for elbow impairment did not provide a possible permanent impairment rating of six percent for the elbow, based upon the grade modifiers Dr. Semble had used. He advised that he used the diagnosis of contusion as he did not know the cause of appellant's traumatic hemarthrosis. The DMA also noted that the 1982 left elbow surgery records were needed to clarify the diagnosis, which could possibly change the impairment rating.

An electromyography and nerve conduction velocity (EMG/NCV) scan testing dated December 7, 2017 revealed bilateral median sensory demyelinating entrapment neuropathies consistent with carpal tunnel syndrome and left ulnar neuropathy.

On December 27, 2017 Dr. Semble provided an amended report based on review of the DMA's December 13, 2017 report and calculated five percent left upper extremity permanent impairment. He opined that since appellant had undergone surgery, this indicated that he sustained more than an elbow sprain. However, Dr. Semble explained that "[a]bsent any medical or

[6] *Id.* at 398, 399, Table 15-4.

[7] *Id.* at 406, Table 15-7.

[8] *Id.* at 410, Table 15-9.

[9] *Id.* at 411.

operative reports, it is difficult to establish what the diagnosis regarding the left elbow was." He further explained that the DMA had correctly reported more than a two grade difference for GMFH. Dr. Semble explained that, based upon the diagnoses of loose body and osteochondral lesion and the GMFH adjustment, he found that appellant had five percent left upper extremity permanent impairment.

On January 10, 2018 OWCP requested clarification from the DMA noting accepted conditions of left elbow hemarthrosis and other unspecified complications of medical care. In a January 13, 2018 amended report, the DMA calculated four percent left upper extremity permanent impairment using the DBI methodology for the diagnosis of loose bodies or osteochondral lesions and two percent permanent impairment using the ROM methodology.

By decision dated February 20, 2018, OWCP granted appellant a schedule award for five percent left upper extremity permanent impairment. On March 15, 2018 appellant requested reconsideration.

In a May 24, 2018 report, Dr. Mark A. Seldes, a Board-certified family medicine physician, using the sixth edition of the A.M.A., *Guides*, determined that appellant had 18 percent left upper extremity permanent impairment using the diagnoses of left ulnar nerve impairment and post-traumatic joint disease. Using Table 15-23,[10] he found nine percent left upper extremity permanent impairment due to left ulnar nerve entrapment. Dr. Seldes also calculated appellant's permanent impairment using Table 15-33,[11] and found appellant had 10 percent permanent impairment for ROM loss. Using the Combined Values Chart, he combined the left upper extremity ROM impairment with the DBI impairment, resulting in a combined 18 percent left upper extremity permanent impairment.

On August 14, 2018 OWCP referred an amended SOAF and medical record for review by the DMA. The SOAF noted that appellant had sustained a traumatic injury on January 26, 1982 and that the claim had been accepted for traumatic left elbow hemarthrosis. It noted that appellant had undergone a permanent impairment rating examination with Dr. Seldes on May 24, 2018. The SOAF noted additional claims and accepted conditions and that appellant was considered totally disabled under OWCP File No. xxxxxx138. It also noted that appellant had undergone a left elbow surgery in 1980.

In an August 16, 2018 report, the DMA, based upon a review of the medical evidence provided and the SOAF, utilized the A.M.A., *Guides* to calculate that appellant had nine percent left upper extremity permanent impairment using the DBI method for the diagnosis of cubital tunnel syndrome. He explained that he could not rate appellant's permanent impairment for post-traumatic degenerative changes as Dr. Seldes' findings were inconsistent with prior medical reports. The DMA also explained that appellant's left upper extremity permanent impairment could not be rated based upon loss of ROM because Dr. Semble's findings were inconsistent with the ROM findings by Dr. Seldes.

[10] *Id.* at 449, Table 15-23.

[11] *Id.* at 474, Table 15-33.

On September 14, 2018 OWCP requested clarification from the DMA to address discrepancies in his report. The accepted conditions were listed as left elbow hemarthrosis, primary left elbow osteoarthritis, and left elbow other specific joint derangements not elsewhere classified. In a September 18, 2018 amended report, the DMA calculated five percent left elbow permanent impairment using the ROM method and six percent left upper extremity permanent impairment using the DBI method for a diagnosis of cubital tunnel syndrome. He explained that appellant had previously been granted a schedule award for five percent permanent impairment of the left elbow, but he was entitled to an additional six percent permanent impairment for his left cubital tunnel syndrome. In conclusion the DMA explained that while appellant had a combined permanent impairment of eleven percent, he was entitled to an additional permanent impairment of six percent.

By decision dated October 17, 2018, OWCP granted appellant a schedule award for an additional 6 percent left upper extremity permanent impairment, resulting in a combined 11 percent left upper extremity permanent impairment.

On November 6, 2018 appellant requested reconsideration. In support thereof he submitted an August 29, 2012 report from Dr. Walter A. Rho, an orthopedic surgeon, regarding osteoarthritis of the left elbow.

By decision dated January 3, 2019, OWCP denied modification. On January 22, 2019 appellant requested reconsideration asserting, in part, that the SOAF was inaccurate.

By decision dated February 13, 2019, OWCP denied modification.

LEGAL PRECEDENT

The schedule award provisions of FECA,[12] and its implementing regulations,[13] 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.[14] 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.[15] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[16] The sixth edition requires identifying the

[12] 5 U.S.C. § 8107.

[13] 20 C.F.R. § 10.404.

[14] *Id.*

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

[16] *Id.*

class of diagnosis (CDX), which is then adjusted by grade modifiers GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[17]

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

> "As the [A.M.A.,] *Guides* caution that if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s).
>
> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify (1) the methodology used by the rating physician (*i.e.*, DBI or ROM) and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. If the [A.M.A.,] *Guides* allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used." (Emphasis in the original.)

ANALYSIS

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

The initial September 19, 2017 SOAF presented to Dr. Semble only listed the accepted condition of left elbow traumatic hemarthrosis and noted that appellant had undergone left elbow surgery in 1980. The second SOAF, dated August 18, 2018, presented to the DMA again only listed left elbow traumatic hemarthrosis and noting a left elbow surgery in 1980. It is OWCP's responsibility to provide a complete and proper frame of reference for a physician by preparing a SOAF.[18] OWCP's procedures dictate that when a DMA, second opinion specialist, or referee physician renders a medical opinion based on a SOAF which is incomplete or inaccurate, or does not use the SOAF as the framework in forming his or her opinion, the probative value of the opinion is seriously diminished or negated altogether.[19] OWCP did not provide Dr. Semble, the second opinion physician, or the DMA with an accurate SOAF as it did identify all of appellant's accepted left elbow conditions, appellant's left elbow arthrotomy and removal of loose bodies on August 22, 1986, any left elbow conditions not accepted by OWCP, and appellant's accepted recurrences of disability.[20] The Board finds that the reports from OWCP's second opinion

[17] *Supra* note 13.

[18] *M.B.*, Docket No. 19-0525 (issued March 20, 2020); *J.N.*, Docket No. 19-0215 (issued July 15, 2019); *Kathryn E. Demarsh*, 56 ECAB 677 (2005).

[19] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.3 (October 1990).

[20] The Board notes that due to the age of the record and the retirement of the record, the current record before the Board does not contain acceptance letters identifying the conditions accepted under the current claim.

physician and the DMA were therefore not based on an accurate factual framework.[21] The Board is therefore unable to determine which diagnosis and examination findings related to appellant's left elbow results in the highest permanent impairment rating of his left elbow.

Once OWCP undertakes development of the record, it has the responsibility to do so in a manner that will resolve the relevant issues in the case.[22] Accordingly, the Board finds that the case must be remanded to OWCP. On remand, OWCP should prepare a complete and accurate SOAF and refer appellant for a new second opinion evaluation to determine his left upper extremity permanent impairment. Following this and such further development as deemed necessary, it 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 13, 2019 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further proceedings consistent with this opinion of the Board.

Issued: December 15, 2020
Washington, DC

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

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

[21] *M.B., supra* note 23; *G.C.*, Docket No. 18-0842 (issued December 20, 2018).

[22] *R.W.*, Docket No. 19-1109 (issued January 2, 2020); *D.S.*, Docket No. 19-0292 (issued June21, 2019); *G.C., id.*