United States Department of Labor
Employees' Compensation Appeals Board

R.C., Appellant	)	
and	)	**Docket No. 19-1385**
	)	**Issued: September 8, 2020**
EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, OFFICE OF HUMAN RESOURCES, Washington, DC, Employer	)	

Appearances:
Justin Dale, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

ORDER REMANDING CASE

Before:
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

On June 11, 2019 appellant, through counsel, filed a timely appeal from a January 23, 2019 merit decision of the Office of Workers' Compensation Programs (OWCP). The Clerk of the Appellate Boards assigned the appeal Docket No. 19-1385.

On June 17, 2008 appellant, then a 45-year-old systems analyst, filed an occupational disease claim (Form CA-2), alleging that she developed carpal tunnel syndrome (CTS) due to factors of her federal employment, including frequent use of a computer and mouse. By decision dated November 6, 2008, OWCP accepted the claim for right CTS.

[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.

Appellant filed a claim for a schedule award (Form CA-7) on November 14, 2013 based on a July 18, 2012 report from Dr. Rida N. Azer, a Board-certified orthopedic surgeon, who opined that she had 35 percent permanent impairment of the right upper extremity.

OWCP referred appellant for a second opinion examination with Dr. Mohammad Zamani, a Board certified orthopedic surgeon. In his report dated January 20, 2015, Dr. Zamani found that appellant had reached maximum medical improvement (MMI) three months after her right carpal tunnel release surgery on January 7, 2010, which had been performed by Dr. Azer. He opined that appellant had three percent permanent impairment of the right upper extremity.

On June 8, 2015 Dr. Lawrence A. Manning, an OWCP district medical adviser (DMA) and orthopedic surgeon, reviewed the medical evidence of record and determined that appellant's date of MMI was January 20, 2015, the date of Dr. Zamani's second opinion report. Dr. Manning opined that appellant had a total of three percent permanent impairment of the right upper extremity.

By decision dated September 28, 2015, OWCP granted appellant a schedule award for three percent permanent impairment of the right arm.

In a decision dated July 29, 2016, OWCP expanded the acceptance of appellant's claim to include the additional condition of left upper limb CTS.

On September 26, 2016 appellant, through counsel, requested reconsideration of the September 28, 2015 decision and submitted a September 12, 2016 report from Dr. Robert W. Macht, a Board-certified orthopedic surgeon. Dr. Macht opined that appellant had reached MMI as of December 31, 2012 and had five percent permanent impairment of the right upper extremity and four percent permanent impairment of the left upper extremity.

OWCP determined that a conflict of medical opinion existed between Dr. Macht, appellant's treating physician, and Dr. Zamani, the second opinion physician. It referred appellant to an impartial medical examiner (IME) to resolve the conflict of medical opinion evidence. In a referee examination report dated January 5, 2017, Dr. Sankara R. Kothakota, a Board-certified orthopedic surgeon, diagnosed status-post right carpal tunnel surgery and determined that appellant had reached MMI for this condition. He further found that appellant was status-post carpal tunnel syndrome on the left, with no surgical intervention. Dr. Kothakota opined that appellant had three percent permanent impairment of the right upper extremity and three percent permanent impairment of the left upper extremity.

In a decision dated February 23, 2017, OWCP modified in part and vacated in part its prior September 28, 2015 decision and granted a schedule award for three percent permanent impairment of the left upper extremity with an MMI date of January 5, 2017. It further found no entitlement to an additional award for the right upper extremity.

On May 23, 2017 appellant, through counsel, requested reconsideration of the February 23, 2017 decision. In support of her request for reconsideration, appellant submitted an April 6, 2017 report from Dr. Macht where he reviewed the January 5, 2017 report of Dr. Kothakota and found

that he incorrectly applied the procedures set forth in the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2]

OWCP found a conflict in the medical opinion evidence and referred appellant's claim to Dr. Robert A. Smith a Board-certified orthopedic surgeon selected as an IME, to resolve the conflict. In his October 11, 2017 referee examination report, Dr. Smith found that appellant's right hand showed a well-healed scar on the volar aspect of the wrist consistent with prior carpal tunnel release and there was no atrophy or deformity about the wrist, hand, or fingers. There was full range of motion (ROM) of the wrist and finger joints. The left hand and wrist showed no evidence of prior surgery and there was no atrophy or deformity present. There was full ROM of the left wrist and finger joints. There were negative Tinel's and Phalen's signs of both the right and left upper extremities. Dr. Smith opined that appellant had reached MMI as of October 11, 2017, the date of his impairment examination. He concluded that appellant had three percent permanent impairment of the right upper extremity and zero percent permanent impairment of the left upper extremity.

By decision dated October 20, 2017, OWCP modified in part and vacated in part its February 23, 2017 decision, finding that appellant had previously received a schedule award for three percent permanent impairment of the right upper extremity and the medical evidence of record was insufficient to establish a greater schedule award. Appellant also had zero percent permanent impairment of the left upper extremity, which resulted in an overpayment of compensation of the total award previously paid.

On September 28, 2018 appellant, through counsel, requested reconsideration and argued that appellant was entitled to a schedule award for five percent impairment of the right upper extremity and four percent permanent impairment of the left upper extremity. In support of her request, she submitted an April 19, 2018 supplemental report from Dr. Macht, where he utilized Table 15-23, page 449, of the A.M.A., *Guides*, and found that her condition fell under grade modifier 2 rather than a grade modifier of zero as previously found by Dr. Smith in his October 11, 2017 report.

On January 4, 2019 Dr. Arthur S. Harris, an OWCP district medical adviser (DMA) and orthopedic surgeon, reviewed the medical evidence of record and concurred with Dr. Smith's October 11, 2017 report and his impairment calculation for zero percent permanent impairment of the left upper extremity.

By decision dated January 23, 2019, OWCP denied modification of its October 20, 2017 decision.

Regarding the application of ROM or diagnosis-based impairment (DBI) 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

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

> 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.)[3]

The Bulletin further advises:

> "If the rating physician provided an assessment using the DBI 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. If the medical evidence of record is [in]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."[4]

As noted, FECA Bulletin No. 17-06 indicates that in measuring ROM, the evaluator should obtain three independent measurements and use the greatest measurement to determine the extent of impairment.[5] The evidence presently of record fails to establish that Dr. Smith properly measured the ROM of appellant's bilateral upper extremities three times prior to rating the extent of her permanent impairment. It was therefore incumbent upon the DMA to obtain the necessary ROM measurements to complete the full rating using both the ROM and DBI methodologies and thereafter identify the higher impairment rating for the claims examiner.[6]

The Board therefore finds that because OWCP failed to follow the procedures set forth in FECA Bulletin No. 17-06, the case must be remanded.[7] On remand, OWCP should further develop the medical evidence, including referral to a medical examination to obtain three independent ROM measurements as required under FECA Bulletin No. 17-06. Following this and other such development as deemed necessary, it shall issue a *de novo* decision.[8]

[3] FECA Bulletin No. 17-06 (May 8, 2017).

[4] *Id.*

[5] *Id.*; *see also J.V.*, Docket No. 18-1052 (issued November 8, 2018).

[6] *See M.D.*, Docket No. 18-1703 (issued January 18, 2019) (finding that a DMA should advise as to the medical evidence necessary to complete the ROM method of rating if the medical evidence of record is insufficient to rate appellant's impairment using loss of ROM).

[7] *R.A.*, Docket No. 18-1331 (issued April 24, 2019); *F.V.*, Docket No. 18-0427 (issued November 9, 2018).

[8] *M.S.*, Docket No. 18-0656 (issued October 28, 2019).

IT IS HEREBY ORDERED THAT the January 23, 2019 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this order of the Board.

Issued: September 8, 2020
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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