United States Department of Labor
Employees' Compensation Appeals Board

J.P., Appellant	)	
and	)	**Docket No. 23-0434**
	)	**Issued: October 25, 2023**
DEPARTMENT OF HOMELAND SECURITY, U.S. CUSTOMS & BORDER PROTECTION, PORT OF CALEXICO, Calexico, CA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On February 3, 2023 appellant filed a timely appeal from a January 3, 2023 merit 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 greater than seven percent permanent impairment of his right upper extremity and seven percent permanent impairment of his left upper extremity, for which he previously received schedule award compensation.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On November 15, 2019 appellant, then a 53-year-old agriculture specialist, filed an occupational disease claim (Form CA-2) alleging that he sustained bilateral carpal tunnel syndrome due to factors of his federal employment including repetitive employment duties over the past 24 years inspecting luggage, vehicles, and boxes of produce. He noted that he first became aware of his condition on July31, 2019 and realized its relation to his federal employment on August 14, 2019. Appellant stopped work on July 30, 2020. OWCP accepted the claim for unspecified right wrist sprain, unspecified left wrist sprain, and subsequently expanded the acceptance of his claim to include bilateral carpal tunnel syndrome, and trigger finger of the right middle, left index, and left middle fingers.

On July 30, 2020 Dr. Todd Runyan, a Board-certified orthopedic surgeon, performed right endoscopic carpal tunnel release with ring and middle A1 pulley release. On September 24, 2020 he performed left endoscopic carpal tunnel release with index and middle A1 pulley release. The procedures were authorized by OWCP.

In a March 17, 2021 report, Dr. Runyan noted that appellant was seen for evaluation of his right wrist, right middle and ring fingers, left wrist, and left index and middle fingers. He opined that appellant could return to work with no restrictions.

On June 24, 2021 OWCP referred appellant, along with the case file, a statement of accepted facts (SOAF), and a series of questions to Dr. William Curran, Jr., a Board-certified orthopedic surgeon, for a second opinion medical examination and determination as to whether appellant sustained permanent impairment and to assign a date of maximum medical improvement (MMI).

In an August 17, 2021 report, Dr. Curran indicated that he reviewed the medical evidence of record, noting that the claim was accepted for the conditions of bilateral wrist sprains, bilateral carpal tunnel syndrome, trigger finger, right third and fourth digits, and trigger finger, left second and third digits. He reported that appellant underwent a left trigger thumb release as well as a trigger finger release of the index and middle fingers. Dr. Curran provided findings on physical examination, including range of motion (ROM) measurements for the digits of both hands. He referred to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[2] to calculate his impairment rating for left and right carpal tunnel syndrome, utilizing both the diagnosis-based impairment (DBI) and ROM methodology. Dr. Curran utilized Table 15-23 (Entrapment/Compression Neuropathy Impairment), page 449, to determine that appellant had five percent permanent impairment of the left median nerve and five percent permanent impairment of the right median nerve.[3] Under the DBI methodology, he further found six percent digit impairment of the right index finger, six percent digit impairment of the right middle finger, six percent digit impairment of the left index finger, and six percent digit impairment of the left middle finger. Dr. Curran also applied the ROM

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

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

rating method, noting that ROM was normal for the right middle and ring fingers and the left second and third fingers under Table 15-31 on page 470.

Dr. Curran discussed his calculations using the DBI methodology for digit impairment as set forth in the A.M.A., *Guides*. Pertaining to the right third trigger finger, he utilized the DBI rating method to find that, under Table 15-2 (Digit Regional Grid), page 392, the class of diagnosis (CDX) for digital stenosing tenosynovitis was a Class 1 impairment, grade C, with a default value of six percent for the digit.[4] Dr. Curran assigned a grade modifier for functional history (GMFH) of 1 based on pain, numbness, weakness, and stiffness amounting to a mild problem. He assigned a grade modifier for physical examination (GMPE) of 1 due to mild decreased ROM. Dr. Curran found that a grade modifier for clinical studies (GMCS) was not applicable. He utilized the net adjustment formula (GMFH - CDX) + (GMPE - CDX) = (1-1) + (1-1) = 0, which resulted in a grade C or six percent permanent impairment of the right third finger, which he converted to one percent permanent impairment of the right hand and one percent permanent impairment of the right upper extremity, pursuant to Table 15-12, page 421.

Dr. Curran utilized the DBI rating method for the right fourth trigger finger, to find that, under Table 15-2, page 392, the CDX for appellant's digital stenosing tenosynovitis resulted in a Class 1 impairment, with a default value of six percent. He assigned a GMFH of 1 and a GMPE of 1. Dr. Curran found that a GMCS was not applicable. He utilized the net adjustment formula (GMFH - CDX) + (GMPE - CDX) = (1-1) + (1-1) = 0, which resulted in a grade C or six percent permanent impairment of the right third finger, which he converted to one percent permanent impairment of the right hand and one percent permanent impairment of the right upper extremity, pursuant to Table 15-12, page 421.

Dr. Curran determined that combining the right third and right fourth finger digit impairments would yield two percent permanent impairment of the right hand, converting to two percent permanent impairment of the right upper extremity.

Pertaining to the left second trigger finger, Dr. Curran utilized the DBI rating methodology to find that, under Table 15-2, page 392, the CDX for appellant's digital stenosing tenosynovitis resulted in a Class 1 impairment with a default value of six percent.[5] He assigned a GMFH of 1 and a GMPE of 1. Dr. Curran found that a GMCS was not applicable. He utilized the net adjustment formula (GMFH - CDX) + (GMPE - CDX) = (1-1) + (1-1) = 0, which resulted in a grade C or six percent permanent impairment of the left second finger, which he converted to one percent permanent impairment of the left hand and one percent permanent impairment of the left upper extremity, pursuant to Table 15-12, page 421.

For the left third trigger finger, Dr. Curran utilized the DBI rating method to find that, under Table 15-2, page 392, the CDX for appellant's digital stenosing tenosynovitis resulted in a Class 1 impairment with a default value of six percent. He assigned a GMFH of 1 and a GMPE of 1. Dr. Curran found that a GMCS was not applicable. He utilized the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (1-1) + (1-1) = 0, which resulted in a grade

[4] *Id.* at 392, Table 15-2.

[5] *Id.*

C or six percent permanent impairment of the left third finger, which he converted to one percent permanent impairment of the left hand and one percent permanent impairment of the left upper extremity, pursuant to Table 15-12, page 421.

Dr. Curran combined the ratings for the left second and left third finger digit impairments, which yielded two percent permanent impairment of the left hand, converting to two percent permanent impairment of the left upper extremity. He determined that appellant reached MMI on March 17, 2021. On September 22, 2021 OWCP requested that Dr. David J. Slutsky, a Board-certified hand surgeon serving as an OWCP district medical adviser (DMA), review the case for a determination on whether appellant sustained a permanent impairment of the upper extremities and date of MMI.

In an October 5, 2021 report, Dr. Slutsky reported that he could not perform the impairment rating of appellant's bilateral carpal tunnel syndrome and digits due to the inconsistent data provided by Dr. Curran. He reported that Dr. Curran incorrectly listed procedures appellant underwent and evaluated the wrong digits when determining appellant's impairment rating. Dr. Curran reported a left trigger thumb release as well as a trigger finger release of the left index and middle fingers, but according to the operative report dated September 24, 2020, appellant underwent a trigger finger release of the left index and middle fingers, but not the left thumb. He also did not perform an impairment rating for a left trigger thumb release. Dr. Slutsky reported that, with regard to the ROM impairment method, Dr. Curran stated that the finger ROM of the right index and middle fingers and left index and middle finger were normal, but he did not provide the ROM findings for the individual fingers. He noted, "he listed the [ROM] for the third and fourth digit, but it was the index and middle fingers bilaterally not the ring finger." Additionally, Dr. Slutsky listed the metacarpophalangeal joint extension of 0 degrees as a 0 percent permanent impairment according to Table 15-31 (Finger Range of Motion), page 470, of the sixth edition of the A.M.A., *Guides*, but this would be a seven percent permanent impairment. He concluded that, because of the confusing data, a digit ROM impairment rating could not be performed.

On December 21, 2021 appellant filed a claim for compensation (Form CA-7) for a schedule award.

By decision dated March 29, 2022, OWCP granted appellant a schedule award for seven percent permanent impairment to the right upper extremity and seven percent permanent impairment to the left upper extremity. The award ran for 43.68 weeks from August 17, 2021 through June 18, 2022 and was based on the August 17, 2021 report of Dr. Curran and the October 5, 2022 DMA report.

On October 7, 2022 appellant requested reconsideration. In support of his request, he provided a June 27, 2022 medical report from Dr. Gregory Mack, a Board-certified orthopedic surgeon. Dr. Mack provided physical examination findings of the bilateral upper extremities and reviewed Dr. Curran's second opinion impairment rating. He compared his examination findings with those of Dr. Curran and reported inconsistencies in the responses as appellant did have stiffness and decreased motion of his fingers as noted in the report and was unable to fully flex his fingertips to the palm.

By decision dated January 3, 2023, OWCP denied modification of the March 29, 2022 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA,[6] and its implementing federal regulations,[7] 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. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such a determination is a matter, which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*, published in 2009.[8] 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.[9]

The sixth edition requires identifying the impairment class for the CDX, which is then adjusted by a GMFH, a GMPE, and/or a GMCS.[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11]

The A.M.A., *Guides* also provides that the ROM impairment is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other diagnosis-based sections are applicable.[12] If ROM is used as a stand-alone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are measured and added.[13] Adjustments for functional history may be made if the evaluator determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[14]

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] For decisions issued after May 1, 2009 the sixth edition of the A.M.A., *Guides* is used. A.M.A., *Guides*, (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); *see also id*. at Chapter 3.700, Exhibit 1 (January 2010).

[9] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

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

[11] *Id*. at 521.

[12] *Id*. at 461.

[13] *Id*. at 473.

[14] *Id*. at 474.

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*."[15] (Emphasis in the original.)

The Bulletin further advises:

> "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."[16]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and percentage of permanent impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[17]

ANALYSIS

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

On August 17, 2021 OWCP referred appellant, along with a SOAF and a series of questions, to Dr. Curran, OWCP referral physician. In an August 17, 2021 report, Dr. Curran utilized the sixth edition of the A.M.A., *Guides* and determined that appellant had seven percent permanent impairment of the right upper extremity and seven percent permanent impairment of the left upper extremity.

OWCP subsequently referred the report to Dr. Slutsky, serving as OWCP's DMA, to review the impairment rating pertaining to appellant's bilateral upper extremities. In his October 5, 2021 report, Dr. Slutsky reported that he could not rate appellant's bilateral carpal

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

[16] *Id.*

[17] *See D.J.*, Docket No. 19-0352 (issued July 24, 2020).

tunnel syndrome and the digits due to the inconsistent data provided by Dr. Curran. He found that Dr. Curran incorrectly listed the procedures appellant underwent, evaluated the wrong digits when calculating appellant's impairment rating, and incorrectly interpreted and applied the A.M.A., *Guides* throughout his ratings calculations. The record reflects that Dr. Mack, appellant's treating physician, also found inconsistent examination findings in Dr. Curran's report, which did not reflect appellant's examination or impairment.[18]

The Board notes that Dr. Curran did not provide detailed findings with regard to all of appellant's accepted upper extremity conditions, nor did he evaluate the correct digits or explain his findings in accordance with the A.M.A., *Guides*. Once OWCP undertook development of the evidence by referring appellant to Dr. Curran, it had an obligation to obtain a proper evaluation that sufficiently addresses the issues in this case.[19] OWCP's procedures provide that when OWCP refers the schedule award claim for a second opinion examination, and this report does not contain a discussion of how the impairment rating was calculated, clarification should be sought.[20] The case must therefore be remanded for further development.[21]

On remand OWCP shall refer appellant, along with an updated SOAF and a series of questions to a new second opinion specialist for an opinion on the nature and extent of appellant's bilateral upper extremity impairment.[22] After this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

[18] *W.W.*, Docket No. 18-0093 (issued October 9, 2018).

[19] *Id.*; *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

[20] *J.W.*, Docket No. 22-0223 (issued August 23, 2022).

[21] *K.W.*, Docket No. 22-0320 (issued July 28, 2022).

[22] *S.S.*, Docket No. 19-1067 (issued June 24, 2022).

ORDER

IT IS HEREBY ORDERED THAT the January 3, 2023 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: October 25, 2023
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board