United States Department of Labor
Employee' Compensation Appeals Board

M.P., Appellant	)	
and	)	**Docket No. 17-0275**
	)	**Issued: August 14, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Hartford, CT, Employer	)	

Appearances:
William Bothwell, 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 November 17, 2016 appellant, through her representative, filed a timely appeal from August 10 and November 7, 2016 merit decisions of the Office of Workers' Compensation Programs (OWCP).[2] Pursuant to the Federal Employees' Compensation Act[3] (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] Appellant also filed a timely request for oral argument in this case. By order dated April 24, 2017, the Board, after exercising its discretion, denied appellant's request for oral argument as oral argument would further delay issuance of a Board decision and not serve a useful purpose. *Order Denying Request for Oral Argument*, Docket No. 17-0275 (issued April 24, 2017).

[3] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has established that she has more than eight percent permanent impairment of the left upper extremity for which she previously received a schedule award.

FACTUAL HISTORY

On January 30, 2014 appellant, then a 54-year-old letter carrier, filed a traumatic injury claim (Form CA-1) alleging that on January 29, 2014 she sustained a left wrist fracture when she slipped on the floor and landed on her left wrist while in the performance of duty. By decision dated February 13, 2014, OWCP accepted the claim for left distal radius fracture. By decision dated June 16, 2014, it accepted the claim for the additional conditions of left carpal tunnel syndrome and left cubital tunnel syndrome. Appellant stopped work on January 29, 2014 and returned on April 28, 2014. She again stopped work on May 29, 2014 and did not return, receiving medical and wage-loss compensation benefits.

On February 14, 2014 appellant underwent open reduction/internal fixation of the left wrist. On July 3, 2014 she underwent carpal tunnel release and cubital tunnel release with subcutaneous transposition of the ulnar nerve. Appellant sought treatment with Dr. Matthew P. Gordon, a Board-certified orthopedic surgeon.

In a September 24, 2015 medical report, Dr. Gordon reported that in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009) (A.M.A., *Guides*),[4] appellant sustained a combined 15 percent permanent impairment of the left upper extremity. He reported five percent permanent impairment for a diagnosis of distal radius fracture under class 1 placement E,[5] six percent permanent impairment for cubital tunnel syndrome, and four percent permanent impairment for carpal tunnel syndrome.[6]

On October 22, 2015 appellant filed a claim for a schedule award (Form CA-7).

On November 6, 2015 OWCP routed Dr. Gordon's report, a statement of accepted facts (SOAF), and the case file to Dr. David Krohn, Board-certified in internal medicine serving as an OWCP district medical adviser (DMA), for review and determination regarding whether appellant sustained a permanent impairment of the left upper extremity and date of maximum medical improvement (MMI). OWCP noted accepting the additional condition of left lesion of ulnar nerve.

In a November 20, 2015 report, Dr. Krohn disagreed with Dr. Gordon's impairment rating. He determined that, based on examination findings, there was no ratable impairment of the left upper extremity due to residuals of the work-related injury.

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

[5] *Id.* at 396, Table 15-3.

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

By letter dated December 4, 2015, OWCP provided Dr. Gordon a copy of Dr. Krohn's November 20, 2015 report and SOAF for review, requesting that he respond to the concerns presented by the DMA within 30 days.

In a December 31, 2015 addendum report, Dr. Gordon disagreed with Dr. Krohn's impairment rating and argued that his initial impairment was correct based on evidence of consistent and ongoing dysfunction of the left upper extremity.

OWCP referred appellant, a series of questions, the SOAF, and the medical record to Dr. Steven A. Silver, a Board-certified orthopedic surgeon, for a second opinion examination and determination as to whether appellant sustained a permanent impairment and the date of MMI.

In his March 1, 2016 medical report, Dr. Silver reviewed the case record and summarized the relevant medical and diagnostic reports. Utilizing the sixth edition of the A.M.A., *Guides*, he provided a diagnosis of left wrist fracture, and class 1 diagnosis for residual symptoms and functional loss.[7] Dr. Silver assigned a grade modifier of 2 for functional history due to pain with symptoms and difficulty in self-care;[8] a grade modifier of 2 for physical examination due to decreased range of motion (ROM);[9] and a grade modifier of 1 for clinical studies which confirmed the pathology.[10] Applying the net adjustment formula, he subtracted 1, the numerical value of the class, from the numerical value of the grade modifier for each applicable component (functional history, physical examination, and clinical studies) and then added those values, resulting in a net adjustment of 2 ((2-1) + (2-1) + (1-1).[11] Application of the net adjustment formula dictated that movement was warranted two places to the right of class 1 default value grade C to grade E based on Table 15-3.[12] Therefore, the diagnosis-based impairment (DBI) rating for appellant's left wrist fracture yielded four percent permanent impairment.[13] With respect to median nerve compression, Dr. Silver utilized Table 15-23 to calculate two percent permanent impairment of the left upper extremity.[14] For ulnar nerve compression, he utilized Table 15-21 to calculate another two percent permanent impairment of the left upper extremity.[15] Dr. Silver concluded that MMI was reached on September 3, 2015.

OWCP routed Dr. Silver's report and the case file to Dr. Jovito Estaris, Board-certified in occupational medicine serving as an OWCP DMA, for review and determination regarding

[7] *Supra* note 5.

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

[9] *Id.* at 408, Table 15-8.

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

[11] *Id.* at 411.

[12] *Supra* note 5.

[13] *Id.*

[14] *Supra* note 6.

[15] *Id.* at 444.

whether appellant sustained a permanent impairment of the left upper extremity and date of MMI. The request noted the accepted conditions of left closed fracture of lower end of radius, left carpal tunnel syndrome, left cubital tunnel syndrome, and left lesion of ulnar nerve.

In an April 21, 2016 medical report, Dr. Estaris provided a diagnosis of class 1 for left fracture distal radius. He assigned a grade modifier of 2 for functional history due to pain with normal activity. Dr. Estaris assigned a grade modifier of 1 for physical examination, explaining that total joint ROM of the wrist was nine percent based on Dr. Silver's measurements. No grade modifier was assigned for clinical studies as an x-ray of the wrist was used for placement of the diagnosis. Applying the net adjustment formula resulted in 1, warranting movement one place to the right of class 1 default value grade C to grade D for four percent permanent impairment of the upper left extremity. Dr. Estaris further calculated four percent permanent impairment for left carpal tunnel syndrome and five percent permanent impairment for left cubital tunnel syndrome based on entrapment/compression neuropathy.[16] He combined the four percent left wrist fracture impairment with the four percent impairment for carpal tunnel syndrome as both conditions were in the wrist, totaling eight percent permanent impairment. Dr. Estaris then added an additional 5 percent impairment for left cubital tunnel syndrome, resulting in a combined 13 percent permanent impairment of the left upper extremity.

In another May 12, 2016 report, Dr. Estaris reported that appellant sustained four percent permanent impairment due to fracture of the left distal radius. He further determined that left carpal tunnel syndrome resulted in four percent permanent impairment while left cubital tunnel syndrome resulted in two percent impairment. Utilizing the formula for multiple simultaneous neuropathy, Dr. Estaris determined that appellant sustained five percent permanent impairment for entrapment.[17] He combined four percent for radial fracture with five percent for entrapment, resulting in nine percent permanent impairment of the left upper extremity.

OWCP requested that Dr. Estaris provide clarification pertaining to his impairment rating, noting that he appeared to have rated two diagnoses of the left wrist and that the A.M.A., *Guides* only allowed for the most impairing diagnosis to be rated.

In a June 3, 2016 addendum report, Dr. Estaris reported that the A.M.A., *Guides* provides that in rare cases, the examiner may combine multiple impairments within a single region if the most impairing diagnosis does not adequately reflect the losses.[18] He further noted that peripheral nerve impairment may be combined with the DBI at the upper extremity as long as the DBI does not encompass the nerve impairment.[19] Dr. Estaris explained that appellant's limited ROM of the left wrist was explained by the fracture radius. However, the fracture did not encompass the symptoms of numbness and tingling, as well as decrease sensation to the left thumb and index finger. Dr. Estaris noted that these were typical symptoms of median nerve neuropathy at the wrist for carpal tunnel syndrome, which was further confirmed by

[16] *Supra* note 6.

[17] *Id.* at 448.

[18] *Id.* at 419, 15.3f.

[19] *Id.* at 15.4.

electromyography and nerve conduction studies. He determined that in appellant's case, peripheral nerve impairment for carpal tunnel syndrome could be combined with the DBI for the radius fracture, resulting in eight percent permanent impairment for the left wrist. Dr. Estaris concluded that there was no change in the impairment rating provided on April 21, 2016.

On June 17, 2016 OWCP requested Dr. Estaris provide clarification with regard to his impairment rating, noting that he had previously provided nine percent permanent impairment rating, as well as an eight percent permanent impairment rating of the left upper extremity, for permanent impairment of the left wrist.

On June 24, 2016 Dr. Estaris resubmitted his June 3, 2016 report finding an eight percent permanent impairment of the left upper extremity, due to impairment of the left wrist.

By letter dated July 8, 2016, OWCP routed the reports of Dr. Estaris to Dr. Silver for review and comment, noting that the two physicians provided different impairment ratings.

In a July 15, 2016 addendum report, Dr. Silver reported that he would yield to Dr. Estaris' eight percent impairment finding, noting reference to Table 15-23.[20]

By decision dated August 10, 2016, OWCP granted appellant a schedule award for eight percent permanent impairment of the left upper extremity. The date of MMI was noted as September 30, 2015. OWCP noted that the percentage of impairment was based on the medical findings and reports of Dr. Silver and Dr. Estaris.

On August 24, 2016 appellant requested an oral hearing before an OWCP hearing representative.

On October 11, 2016 appellant, through her representative, requested the appeal be changed to review of the written record.

In support of the claim, appellant's representative submitted a memorandum arguing that she was entitled to 16 percent permanent impairment of the left upper extremity. He alleged that since loss of ROM was present, appellant's permanent impairment should alternatively be rated based on Section 15.7 of the A.M.A., *Guides*, for loss of ROM. Appellant's representative reported that loss of ROM warranted 11 percent impairment while entrapment resulted in 5 percent impairment, totaling a combined permanent impairment rating of 16 percent.

By decision dated November 7, 2016, OWCP's hearing representative affirmed the August 10, 2016 decision finding that appellant was properly awarded eight percent permanent impairment of the left upper extremity.

LEGAL PRECEDENT

Section 8149 of FECA delegates to the Secretary of Labor the authority to prescribe rules and regulations for the administration and enforcement of FECA. The Secretary of Labor has

[20] *Supra* note 6.

vested the authority to implement FECA program with the Director of OWCP.[21] Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions, and organs of the body.[22] 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 under the law, good administrative practice requires the use of uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[23]

The sixth edition of the A.M.A., *Guides* was first printed in 2008. Within months of the initial printing, the A.M.A. issued a 52-page document entitled "Clarifications and Corrections, Sixth Edition, *Guides to the Evaluation of Permanent Impairment.*" The document included various changes to the original text, intended to serve as an *erratum*/supplement to the first printing of the A.M.A., *Guides*. In April 2009, these changes were formally incorporated into the second printing of the sixth edition.

As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[24] 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.[25]

The A.M.A., *Guides* notes that, when impairment results directly from a peripheral nerve lesion, on other rating method is applied to this section (15.4 Peripheral Nerve Impairment) to avoid duplication or unwarranted increase in the impairment estimation.[26]

ANALYSIS

OWCP accepted appellant's claim for left distal radius fracture, left carpal tunnel syndrome, left cubital tunnel syndrome, and left lesion of ulnar nerve. The issue is whether appellant sustained more than an eight percent permanent impairment of the left upper extremity for which she received a schedule award. The Board finds this case is not in posture for decision.

[21] *See* 20 C.F.R. §§ 1.1-1.4.

[22] For a complete loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1).

[23] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[24] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

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

[26] A.M.A., *Guides* 423 (note that peripheral nerve impairment may be with DBI at the upper extremity as long as the DBI does not encompass the nerve impairment. *Id*. at 419.

In support of her claim, appellant submitted a September 24, 2015 medical report from his treating physician, Dr. Gordon who opined that she sustained 15 percent permanent impairment to the left upper extremity. After further development the case was referred to Dr. Silver, serving as a second opinion physician, who opined that appellant was entitled to nine percent permanent impairment of the left upper extremity. OWCP routed Dr. Silver's report to Dr. Estaris, serving as OWCP's DMA, who calculated eight percent permanent impairment of the left upper extremity. While Dr. Estaris related that appellant's peripheral nerve impairment for carpal tunnel could be combined with the DBI for appellant left wrist fracture of the radius, he also noted that appellant's limited ROM of the left wrist was explained by the fracture of the radius.[27] He did not however rate appellant's left wrist impairment for utilizing the ROM methodology provided in the A.M.A., *Guides*.

The Board has found that OWCP has inconsistently applied Chapter 15 of the sixth edition of the A.M.A., *Guides* when granting schedule awards for upper extremity claims. No consistent interpretation had been followed regarding the proper use of the DBI or the ROM methodology when assessing the extent of permanent impairment for schedule award purposes.[28] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[29] In *T.H.*, the Board concluded that OWCP physicians were at odds over the proper methodology for rating upper extremity impairment, having observed attending physicians, evaluating physicians, second opinion physicians, impartial medical examiners, and district medical advisers use both DBI and ROM methodologies interchangeably without any consistent basis. Furthermore, the Board observed that physicians interchangeably cited to language in the first printing or the second printing when justifying use of either ROM or DBI methodology. Because OWCP's own physicians were inconsistent in the application of the A.M.A., *Guides*, the Board found that OWCP could no longer ensure consistent results and equal justice under the law for all claimants.[30]

In order to ensure a consistent result and equal justice under the law for cases involving upper extremity impairment, the Board will set aside the August 10 and November 7, 2016 decisions. Utilizing a consistent method for calculating permanent impairment for upper extremities to be applied uniformly, and after such other development as may be deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim for an upper extremity schedule award.

CONCLUSION

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

[27] *Id*.

[28] *T.H.*, Docket No. 14-0943 (issued November 25, 2016).

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

[30] *Supra* note 27.

ORDER

IT IS HEREBY ORDERED THAT the November 7 and August 10, 2016 decisions of the Office of Workers' Compensation Programs are set aside and the case is remanded for further development consistent with this decision.

Issued: August 14, 2017
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