United States Department of Labor
Employees' Compensation Appeals Board

V.A., Appellant	)	
and	)	**Docket No. 14-1621**
	)	**Issued: February 10, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Chicago, IL, 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
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On July 17, 2014 appellant filed a timely appeal from a July 1, 2014 Office of Workers' Compensation Programs' (OWCP) merit decision. 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 on appeal is whether appellant met her burden of proof to establish more than 11 percent permanent impairment of her right upper extremity, and more than 3 percent permanent impairment of her left upper extremity, for which she received a schedule award.

FACTUAL HISTORY

On December 6, 2005 appellant, then a 51-year-old mail handler, was injured at work when a shelf fell on her right lower forearm at work. OWCP accepted appellant's claim for

[1] 5 U.S.C. § 8101 *et seq.*

abrasion of right forearm and fracture of the right ulnar shaft, closed. Appellant received wage-loss compensation and medical benefits. She returned to full duty on May 9, 2006. OWCP expanded the claim to include right wrist ulnocarpal impingement. On December 5, 2006 appellant sustained a recurrence due to worsening of her condition and OWCP authorized a right wrist arthroscopy with debridement, osteotomy and hardware removal procedure on January 30, 2007 and appellant was totally disabled from work since that date. OWCP also authorized a November 12, 2007 left wrist carpal tunnel release and left elbow epicondylectomy. On March 14, 2008 it further authorized removal of right forearm plate and screws and right forearm and wrist tenolysis. OWCP also accepted the conditions of left lateral epicondylitis, left trigger finger, and bilateral carpal tunnel syndrome.[2]

On October 18, 2012 appellant filed a Form CA-7 claim for a schedule award.

By letter dated October 22, 2012, OWCP informed appellant of the type of evidence needed to support her claim and requested that she submit such evidence within 30 days. It explained that the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (A.M.A., *Guides*) (6th ed.) should be utilized to determine whether appellant qualified for impairment. Appellant did not respond. By decision dated December 31, 2012, OWCP denied appellant's claim for a schedule award. It found that the evidence of record did not demonstrate measurable permanent impairment.

On August 15, 2013 OWCP received an August 2013 report from Dr. Harold T. Pye, a treating occupational medicine physician. Dr. Pye determined that appellant had reached maximum medical improvement. He provided an impairment rating work sheet dated August 1, 2013 and opined that appellant had seven percent whole person impairment.

In a report dated January 24, 2014, an OWCP medical adviser explained that the report from Dr. Pye was insufficient to support an impairment rating, noting it was unclear how he arrived at his findings. He recommended a second opinion examination.

On March 6, 2014 OWCP referred appellant to Dr. Allan Brecher, a Board-certified orthopedic surgeon, for a second opinion examination, along with a statement of accepted facts, medical records, and a set of questions.

In a report dated May 6, 2014, Dr. Brecher described appellant's history of injury and treatment and utilized the A.M.A., *Guides*. He noted findings that included limited motion in her right wrist and forearm as well as signs for bilateral carpal tunnel syndrome based upon the Tinel's and compression test. Dr. Brecher determined that appellant had normal strength, intact sensation and intact first dorsal interosseous and thumb abduction. Appellant was nontender at her elbows. Dr. Brecher determined that the forearm supination was 70 degrees and pronation was 40 degrees. He found wrist dorsiflexion of 70 degrees and plantar flexion of 40 degrees. Appellant had intact deviation. Dr. Brecher determined that appellant did not have any problems

[2] On November 21, 2006 appellant filed an occupational disease claim for a left hand injury on August 31, 2006, which was accepted for left lateral epicondylitis and left trigger thumb under claim No. xxxxxx483. Additionally, she had a claim accepted for right carpal tunnel syndrome on August 13, 2008 under claim No. xxxxxx104. These claims have been combined with the claim for the December 6, 2005 injury.

with her shoulder or elbows and thus, she did not qualify for any permanent impairment rating for them. He referred to Table 15-33[3] for her forearm range of motion (ROM) and explained: supination of 70 degrees corresponded to one percent impairment; and, pronation of 40 degrees would equate to two percent impairment. Dr. Brecher advised that, using the ROM method, appellant had three percent impairment for the right forearm.

Dr. Brecher referred to Table 15-32,[4] also using the ROM method for the right wrist, and found flexion of 40 degrees which corresponded to three percent impairment, extension of 70 degrees which corresponded to zero percent impairment, radial deviation of 70 degrees which corresponded to zero percent impairment, and ulnar deviation of 30 degrees which corresponded to zero percent impairment. He opined that appellant had a total impairment of three percent for the right wrist.

Dr. Brecher referred to Table 15-23, under entrapment neuropathy, for appellant's right carpal tunnel syndrome.[5] He determined: using the diagnosis-based impairment (DBI) method, he found the functional history grade modifier corresponded to one for mild intermittent symptoms, the grade modifier for physical findings corresponded to one for minimal palpatory findings, and the grade modifier for test findings corresponded to one as the electromyography (EMG) scan findings confirmed carpal tunnel syndrome. Dr. Brecher determined that the average for these grade modifiers was one. He explained that the *Quick*DASH score of 80 indicated an adjustment of +2 or 3 percent impairment.

Regarding the left side, Dr. Brecher opined that only the carpal tunnel syndrome was ratable and he would provide the same rating of three percent. He opined that appellant had nine percent right upper extremity permanent impairment (three percent forearm range of motion, three percent wrist range of motion, and three percent carpal tunnel syndrome) and three percent left upper extremity (carpal tunnel syndrome) permanent impairment.

In a June 3, 2014 report, Dr. Morley Slutsky, Board-certified in preventive medicine and occupational environmental medicine and, an OWCP medical adviser, determined that appellant had reached maximum medical improvement on May 2, 2014, the date of Dr. Brecher's examination. He found using the DBI method that the final combined right upper extremity impairment was 11 percent which was based on right wrist triangular fibrocartilage complex (TFCC) tear and two percent for the right carpal tunnel syndrome, using the DBI method. For the left arm, also using the DBI method, he concurred with Dr. Brecher, who found three percent for the left carpal tunnel syndrome. Dr. Slutsky found no residuals of the left lateral epicondylitis or left hand trigger fingers at maximum medical improvement and therefore, the final impairment for these conditions was zero percent.

Dr. Slutsky explained his findings. He agreed with Dr. Brecher's rating of three percent for right carpal tunnel syndrome, with the exception of the use of the *Quick*DASH form. He

[3] A.M.A., *Guides* 474.

[4] *Id*. at 473.

[5] *Id*. at 449.

explained that the *Quick*DASH score of 80 percent equated to a severe condition. The medical adviser noted that a functional score greater than 60 was not consistent with mild impairment and suggested that either the presenting diagnosis was incorrect, or that a second diagnosis, including symptom magnification, was overlooked. He indicated that the *Quick*DASH score was invalid for a carpal tunnel syndrome rating.[6] Thus, appellant qualified for an impairment of only two percent, under Table 15-23[7] for entrapment/compression neuropathy impairment for the right wrist. The medical adviser explained that electrodiagnostic testing revealed conduction delay equal to a grade modifier of 1 for clinical studies. Regarding functional history, he referred to page 433 of the A.M.A., *Guides* and noted that there was no indication that appellant was unable to perform at least one of her daily activities. The medical adviser provided a grade modifier of 1. He referred to page 466 of the A.M.A., *Guides* for physical examination findings and found a zero grade modifier. The medical adviser explained that appellant had no sensory or motor loss and thus it could not be used. Thus, appellant had two percent permanent impairment for right carpal tunnel syndrome.

Dr. Slutsky further explained, regarding the right wrist, that the DBI method was the preferred rating method and the claimant was placed into a class 1 for the most impairing diagnosis, a right wrist TFCC tear injury, under Table 15-3 with eight percent grade C default impairment. He referred to Table 15-7, functional history adjustment of the upper extremities and found a grade modifier of one based upon her having to perform functional modification in order to achieve self-care activities.[8] Dr. Slutsky referred to Table 15-8,[9] for physical examination adjustment was equal to a grade modifier of 1 based on tenderness to palpation. He further noted that Dr. Brecher documented only one motion per joint movement, which was not consistent with the validity criteria in section 15.7 for measuring range of motion and thus, those measurements were not valid.[10] Dr. Brecher referred to Table 15-9,[11] for a grade modifier of 2 based on x-rays demonstrating a well-aligned stable right ulnar joint. Using the net adjustment formula, OWCP's medical adviser moved the default grade C impairment to grade D, for nine percent impairment of the right arm due to the TFCC tear. He combined the 2 percent right arm impairment due to carpal tunnel syndrome with the 9 percent for the TFCC tear to yield 11 percent right arm permanent impairment.

By decision dated July 1, 2014, OWCP granted appellant a schedule award for 11 percent permanent impairment of the right arm and 3 percent permanent impairment of the left arm. The award covered the period May 2, 2014 to March 3, 2015.

[6] *Id*. at 445.

[7] *Id*. at 449.

[8] *Id*. at 406.

[9] *Id*. at 408.

[10] *Id*. at 464.

[11] *Id*. at 410.

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 vested the authority to implement the FECA program with the Director of OWCP.[12] 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.[13] 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 American Medical Association, *Guides to the Evaluation of Permanent Impairment* as the appropriate standard for evaluating schedule losses.[14]

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).[15] 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.[16]

ANALYSIS

The issue on appeal is whether appellant has met her burden of proof to establish more than 11 percent permanent impairment of her right upper extremity, or more than 3 percent permanent impairment of her left upper extremity, for which she received a schedule award.

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

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 has been followed regarding the proper use of the DBI or the ROM

[12] *See* 20 C.F.R. §§ 1.1-1.4.

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

[14] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[15] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6a (February 2013); Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

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

methodology when assessing the extent of permanent impairment for schedule award purposes.[17] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[18] In *T.H.*, the Board concluded that OWCP physicians are 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 has observed that physicians interchangeably cite to language in the first printing or the second printing when justifying use of either ROM or DBI methodology. Because OWCP's own physicians are inconsistent in the application of the A.M.A., *Guides*, the Board finds that OWCP can no longer ensure consistent results and equal justice under the law for all claimants.[19]

In light of the conflicting interpretation by OWCP of the sixth edition with respect to upper extremity impairment ratings, it is incumbent upon OWCP, through its implementing regulations and/or internal procedures, to establish a consistent method for rating upper extremity impairment. In order to ensure consistent results and equal justice under the law for cases involving upper extremity impairment, the Board will set aside the July 1, 2014 decision. Following OWCP's development of a consistent method for calculating permanent impairment for upper extremities to be applied uniformly, and 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 this case not in posture for decision.

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

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

[19] *Supra* note 17.

ORDER

IT IS HEREBY ORDERED THAT the July 1, 2014 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: February 10, 2017
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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