# United States Department of Labor
# Employees' Compensation Appeals Board

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| **C.M., Appellant** | ) | |
| | ) | **Docket No. 15-0219** |
| **and** | ) | **Issued: February 9, 2017** |
| **DEPARTMENT OF LABOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, Dallas, TX, Employer** | ) | |

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

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

## ***JURISDICTION***

On October 27, 2014 appellant filed a timely appeal from an April 30, 2014 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.

[1] 5 U.S.C. § 8101 *et seq.*

## ***ISSUE***

The issue is whether appellant has established more than five percent permanent impairment of the right upper extremity and three percent permanent impairment of the left upper extremity, for which she previously received a schedule award.

## ***FACTUAL HISTORY***

OWCP accepted that on or before February 2, 2012 appellant, then a 55-year-old claims examiner, sustained bilateral carpal tunnel syndrome, calcifying tendinitis of both shoulders, and a neck sprain due to repetitive upper extremity motions in the performance of duty.[2]

Appellant was followed by Dr. Marvin Van Hal, a Board-certified orthopedic surgeon. She submitted reports from December 28, 2011 through November 7, 2013 diagnosing bilateral carpal tunnel syndrome, bilateral shoulder impingement, a right rotator cuff tear, bilateral elbow conditions, a cervical spine syndrome, and C5 radiculopathy. Dr. Van Hal attributed these conditions to repetitive upper extremity motions and overuse in appellant's duties as a claims examiner. He obtained imaging and electrodiagnostic studies demonstrating cervical degenerative disc disease, C5 radiculopathy, bilateral acromial impingement, a right supraspinatus tendon tear, and a left subscapularis tendon tear.[3]

On December 17, 2013 appellant filed a claim for a schedule award (Form CA-7). In a January 2, 2014 letter, OWCP advised her of the additional evidence needed to establish her claim, including an impairment rating from her attending physician utilizing the tables and grading schemes of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*).[4]

In response, appellant submitted a November 7, 2013 impairment rating from Dr. Van Hal, reviewing the history of injury and treatment. On examination, Dr. Van Hal found an equivocally positive Phalen's sign at both wrists and a positive Tinel's sign at the right elbow. He diagnosed bilateral carpal tunnel syndrome and shoulder impingement, greater on the right, and C5 radiculopathy by electrodiagnostic studies. Dr. Van Hal found that appellant had reached maximum medical improvement. Regarding the right arm, he noted a grade 1 Class of Diagnosis

[2] OWCP initially denied the claim by July 18, 2012 decision as causal relationship was not established. Following a review of the written record, an OWCP hearing representative reversed the July 18, 2012 decision on October 10, 2012.

[3] December 28, 2011 x-rays of appellant's cervical spine showed degenerative disc disease from C4 to C7. March 1, 2012 x-rays of the right shoulder showed significant impingement with Type II to III acromion. A January 25, 2012 magnetic resonance imaging (MRI) scan of the cervical spine showed stenosis and spondylosis at multiple levels. January 25, 2012 electromyography (EMG) and nerve conduction velocity (NCV) studies showed bilateral carpal tunnel syndrome and right C5 radiculopathy. A June 16, 2012 MRI scan of the right shoulder showed a Type II acromion, supraspinatus and infraspinatus tendinopathy with a tiny full thickness tear of the anterior supraspinatus tendon, and a partial subscapularis tear. A March 20, 2013 MRI scan of the left shoulder showed a Type II to III acromion, mild rotator cuff tendinopathy, and a partial subscapularis tendon tear.

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

(CDX) impairment due to carpal tunnel syndrome. Referring to Table 15-23,[5] Dr. Van Hal assessed a grade 1 modifier for Clinical Studies (GMCS), a grade 2 modifier for Functional History (GMFH) due to pain into the hand requiring a brace and activity modifications, and a grade 2 modifier for findings on Physical Examination (GMPE) due to decreased two-point discrimination. Applying the net adjustment formula of (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), Dr. Van Hal found an average modifier of 1.66, rounded up to 2. He opined that this equaled five percent impairment of the right arm. Regarding the right shoulder, Dr. Van Hal opined that the range of motion (ROM) methodology under section 15.7 was the appropriate means of evaluating appellant's permanent impairment. He found 160 degrees forward flexion, 160 degrees abduction, 40 degrees extension, 20 degrees adduction, 70 degrees external rotation, and 60 degrees internal rotation. Dr. Van Hal found that these ranges of motion equaled 10 percent impairment of the right upper extremity according to Table 15-34.[6] He combined the 5 percent impairment due to carpal tunnel syndrome with the 10 percent impairment due to right shoulder impingement to equal 15 percent permanent impairment of the right arm.

Regarding the left arm, Dr. Van Hal found 10 percent impairment due to shoulder impingement, based on the same ranges of motion observed in the right arm, and using the identical rating methods. He assessed two percent impairment due to carpal tunnel syndrome, based on a CDX of 1, a GMPE of 1 for positive Tinel's and Phalen's signs, and a GMFH of 1 for intermittent symptoms. Dr. Van Hal combined the 10 and 2 percent impairments to equal 12 percent permanent impairment of the left arm. He found no impairment of the upper extremities due to appellant's cervical spine conditions. In a January 12, 2014 addendum, Dr. Van Hal noted that he included an elbow impairment in his calculation, but this would not have altered the percentages of impairment given in his November 7, 2013 report.

On March 11, 2014 OWCP obtained a second opinion from Dr. Sofia M. Weigel, a Board-certified physiatrist, who reviewed the medical record and a statement of accepted facts. Dr. Weigel noted appellant's account of chronic bilateral wrist, elbow, and shoulder pain. On examination, she found no neurologic abnormality of either arm, normal strength and a mildly positive impingement sign in the left shoulder. Dr. Weigel opined that appellant reached maximum medical improvement as of November 7, 2013. Regarding the right arm, utilizing the diagnosis-based impairment (DBI) methodology for rating permanent impairment, she noted a CDX of 1 for a partial rotator cuff tear according to Table 15.5.[7] Dr. Weigel assessed a grade 2 functional history using appellant's responses to a *Quick*DASH questionnaire, a grade 1 physical examination for minimal palpatory findings, and a grade of 2 for clinical studies confirming a partial rotator cuff tear. Applying the net adjustment formula, Dr. Weigel found a net adjustment of 2, resulting in a grade E CDX or two percent impairment of the right upper extremity for a partial rotator cuff tear. Dr. Weigel found three percent impairment of the right arm due to carpal tunnel syndrome, based on clinical studies of a grade 1 for delayed sensory conduction, a

[5] Table 15-23, page 449 of the A.M.A., *Guides* is entitled "Entrapment/Compression Neuropathy Impairment."

[6] Table 15-34, page 475 of the A.M.A., *Guides* is entitled "Shoulder Range of Motion."

[7] Table 15-5, page 401 of the A.M.A., *Guides* is entitled "Shoulder Regional Grid: Upper Extremity Impairments."

grade 2 for functional history for significant intermittent symptoms, and a grade 1 of physical examination for normal two-point discrimination testing.

Regarding the left arm, Dr. Weigel found a grade 1 CDX for partial rotator cuff tear according to Table 15-5. She assessed a GMFH of 2 based on appellant's *Quick*DASH responses, a GMPE of 1 for minimal palpatory findings, and a GMCS of 2 for studies confirming the presence of a partial rotator cuff tear. Applying the net adjustment formula, Dr. Weigel found a grade modifier of 2, resulting in two percent impairment of the left arm due to the rotator cuff tear. Regarding the left wrist, she found a CDX of 1 according to Table 15.3.[8] Dr. Weigel found a GMFH of 2, a GMPE of 1, and no applicable modifier for clinical studies. Applying the net adjustment formula produced a zero net modifier, leaving the default grade of C undisturbed, equaling one percent impairment of the left upper extremity. Dr. Weigel found a total five percent permanent impairment of the right arm and three percent permanent impairment of the left arm. An OWCP medical adviser concurred with Dr. Weigel's assessment and methods of calculation.

By decision dated April 30, 2014, OWCP granted appellant a schedule for five percent permanent impairment of the right upper extremity and three 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 vested the authority to implement the FECA program with the Director of the Office of Workers' Compensation Programs.[9] 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.[10] 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.[11]

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

[8] Table 15-3, page 395 of the A.M.A., *Guides* is entitled "Wrist Regional Grid: Upper Extremity Impairments."

[9] *See* 20 C.F.R. §§ 1.1-1.4.

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

[11] 20 C.F.R. § 10.404. *See also, Ronald R. Kraynak*, 53 ECAB 130 (2001).

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).[12] 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.[13]

## ***ANALYSIS***

The issue on appeal is whether appellant has established greater than five percent permanent impairment of the right upper extremity and three percent permanent impairment of the left upper extremity, for which she previously 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 methodology when assessing the extent of permanent impairment for schedule award purposes.[14] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[15] 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.[16]

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 April 30, 2014 decision. Following OWCP's development of a consistent method for calculating permanent impairment

[12] 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).

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

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

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

[16] *Supra* note 14.

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.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the April 30, 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 9, 2017
Washington, DC

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

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

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