United States Department of Labor
Employees' Compensation Appeals Board

R.E., Appellant	)	
and	)	**Docket No. 16-1618**
	)	**Issued: May 23, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Hartly, DE, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant[1]
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
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On August 8, 2016 appellant, through counsel, filed a timely appeal from an April 29, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (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 more than one percent permanent impairment of the right upper extremity, for which she previously received a schedule award.

[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] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On August 16, 2004 appellant, then a 39-year-old postmaster, filed a traumatic injury claim (Form CA-1) alleging that on July 1, 2004 she developed right arm pain, swelling, and carpal tunnel syndrome. She stopped work on July 8, 2004 and worked intermittently thereafter. On April 27, 2005 OWCP accepted aggravation of right arm lymphedema and later expanded her claim to include right carpal tunnel syndrome, complex regional pain syndrome/myofascial pain syndrome and thoracic outlet syndrome.

Appellant was treated by Dr. Joel M. Rutenberg, a neurologist, from August 31, 2004 to February 16, 2015, for right arm pain and digit numbness. Her history was significant for breast cancer in 2002 with two excisional biopsies and radiation therapy to the right breast. Appellant reported swelling of the right arm diffusely. Dr. Rutenberg diagnosed lymphedema in the right arm related to radiation therapy for breast cancer, and lower trunk radiation-induced brachial plexopathy due to radiation therapy. He opined that appellant had not sustained a specific injury, but was forced to do work which exceeded her limitations set by other physicians which aggravated her pain syndrome.

On March 28, 2006 appellant filed a claim for recurrence of disability (Form CA-2a) alleging that on March 10, 2006 she had pain and swelling of her right shoulder while performing her duties. She stopped work on March 12, 2006. Appellant later submitted a May 5, 2006 report from Dr. Rutenberg who treated her for right arm discomfort, intermittent swelling, numbness of the hand and arm provoked by repetitive movements, lifting, and prolonged driving. Dr. Rutenberg diagnosed mild radiation-induced brachial plexopathy associated with median neuropathy at the wrist, possible superimposed mild complex regional pain syndrome, and myofascial pain syndrome. On June 15, 2006 OWCP denied appellant's claim for a recurrence of disability. Appellant requested a hearing and on August 16, 2006 an OWCP hearing representative set aside the June 15, 2006 decision and instructed OWCP to develop the recurrence claim as a claim for new occupational disease. OWCP developed this under File No. xxxxxx494.[3]

In decisions dated December 11, 2006, August 13, 2007, June 13, 2008, and December 7, 2009, OWCP denied appellant's claim for compensation under File No. xxxxxx494. Appellant appealed to the Board and in an order dated August 5, 2009, the Board set aside the June 13, 2008 decision and remanded the claim to OWCP to combine File Nos. xxxxxx209 and xxxxxx494 and issue a merit decision.[4]

In a January 9, 2013 decision, OWCP changed the accepted conditions to include temporary aggravation of the right arm lymphedema resolved, temporary aggravation of right carpal tunnel syndrome resolved, temporary aggravation of complex regional pain syndrome resolved, and temporary aggravation of thoracic outlet syndrome, resolved. It based its decision on the opinion of Dr. Zohar Stark, a second opinion Board-certified orthopedic surgeon, who concluded the aggravation of her medical conditions resolved when she stopped wearing a shoulder harness at work.

[3] Appellant was separated from employment on March 9, 2007.

[4] Docket No. 08-2529 (issued August 5, 2009).

On March 26, 2014 appellant filed a claim for a schedule award (Form CA-7). She submitted an August 20, 2013 report from Dr. David Weiss, an osteopath, who provided an impairment rating under the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[5] (A.M.A., *Guides*). Dr. Weiss advised that appellant had reached maximum medical improvement (MMI) on August 20, 2013. Appellant's history was significant for right breast cancer and a right lumpectomy with radiation. Dr. Weiss diagnosed cumulative and repetitive trauma disorder superimposed upon preexisting breast cancer diagnosed in 2002, occupational cervical spine syndrome, aggravation of preexisting brachial plexopathy secondary to radiation therapy, right carpal tunnel syndrome, complex regional pain syndrome to the right arm, cumulative and repetitive trauma disorder with aggravation of preexisting lymphedema of the right arm, and subsequent motor vehicle accident in 2008 with aggravation of cervical spine pathology and right arm pathology. He noted that the duties of her employment were the competent producing factor for her subjective and objective findings. Dr. Weiss evaluated carpal tunnel syndrome at the right medial nerve at the wrist under Table 15-23, page 449 of the A.M.A., *Guides* and opined that appellant had six percent permanent impairment of the right arm. For right brachial plexus of the upper trunk (C5 and C6), he calculated 19 percent right arm permanent impairment. For right brachial plexus of the middle trunk (C7), Dr. Weiss determined right upper extremity permanent impairment of three percent. For motor strength deficit for the right biceps (C5 and C6), he found right arm permanent impairment of 25 percent. For motor strength deficit for the right triceps (C7), Dr. Weiss calculated nine percent permanent impairment of the right arm. He noted a final combined right upper extremity permanent impairment of 49 percent.

On December 12, 2013 Dr. Rutenberg reviewed Dr. Weiss' report of August 20, 2013 and agreed with his finding that appellant had 49 percent permanent impairment of the right upper extremity.

In a January 17, 2014 report, an OWCP medical adviser reviewed Dr. Weiss' report and noted that he had found deficits with upper extremity motor weakness and sensory deficit which were a significant variance from other physician's findings on physical examination. The medical adviser recommended a second opinion referral.

On April 8, 2014 OWCP referred appellant to Dr. Stephen F. Penny, a Board-certified neurologist, for a second opinion regarding whether she had permanent impairment attributable to her accepted conditions. In a June 11, 2014 report, Dr. Penny noted that appellant's history was significant for brachial plexopathy, breast cancer, carpal tunnel syndrome, hypertension, and recurrent major depression. Appellant's surgical history included a breast biopsy and lymph node removal. Current symptoms included pain and swelling in the right arm, specifically the right shoulder as well as in the right forearm, wrist, and thumb, difficulty lifting the right arm, and pain radiating down her right arm to the forearm and wrist. Dr. Penny noted findings of pain with passive range of motion (ROM) of the right shoulder above 70 degrees, pain with internal and external rotation of the right shoulder, pain with passive ROM of the right wrist, tenderness over the right lateral epicondyle, Tinel's sign at the right wrist, full right elbow ROM, and full right wrist ROM. He noted that assessment of right arm strength was difficult due to submaximal effort caused by pain, but appeared to be 4+/5 in proximal and distal muscles,

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

decreased light touch sensation in the entire right arm. Dr. Penny opined that appellant had developed a radiation induced right brachial plexopathy related to her treatment for breast cancer and lymphedema. He indicated that musculoskeletal pain involving the shoulder and upper arm and regional pain syndrome contributed to her ongoing symptoms. Dr. Penny noted that appellant had evidence of mild carpal tunnel syndrome by electromyogram (EMG). He noted that appellant had reached maximal medical improvement. Dr. Penny agreed with Dr. Rutenberg's finding that appellant had 49 percent impairment of the right upper extremity.

In a September 19, 2014 report, an OWCP medical adviser reviewed Dr. Penney's report. He indicated that Dr. Penny had provided nonspecific findings of a brachial plexus lesion and 4+/5 right arm strength, but did not mention what muscles were impacted, what nerves innervated, or how this related to the brachial plexus. He further noted that Dr. Penny had agreed with the 49 percent right arm permanent impairment by Dr. Weiss. However, he had not performed a rating examination with calculations. Dr. Penny was asked to perform his own calculations, based upon his own clinical findings, but he failed to do so. The medical adviser recommended that OWCP refer appellant to another second opinion physician with complete documentation of all clinical findings and calculations.

On October 7, 2014 OWCP advised appellant that the second opinion report from Dr. Penny failed to contain an independently derived impairment rating consistent with the A.M.A., *Guides,* as requested and the medical adviser recommended appellant be sent for another second opinion evaluation to determine impairment.

In letters dated October 15 and 20, 2014, counsel indicated that the OWCP referral physician, Dr. Penny, agreed with Dr. Weiss' impairment determination and therefore appellant should be granted a schedule award for 49 percent permanent impairment of the right upper extremity.

On April 8, 2014 OWCP referred appellant for a new second opinion examination with Dr. Willie E. Thompson, a Board-certified physiatrist, for a determination of whether appellant had permanent impairment due to her accepted conditions. In an October 21, 2014 report, Dr. Thompson noted that the underlying etiology of appellant's complaints related to the mastectomy performed in 2002 with residuals of chronic lymphedema. He noted other accepted conditions included aggravation of right upper extremity lymphedema, right carpal tunnel syndrome, right complex regional pain syndrome with myofascial pain, and right thoracic outlet syndrome. Dr. Thompson noted that under the A.M.A., *Guides* there was no diagnosis for persistent aggravation of the chronic lymphedema to the right arm and, therefore, the impairment rating for a chronic lymphedema was zero percent. He advised that there was no clinical evidence to support a diagnosis of complex regional pain syndrome and myofascial pain. Dr. Thompson noted examination revealed normal appearing skin, there was no discoloration or alteration in the overall appearance of the skin with normal motion throughout. With regard to complex regional pain syndrome, pursuant to table 15-26, page 454, the class was zero which resulted in no impairment. Dr. Thompson indicated that the Allen's test was normal and there was no evidence of any residuals of thoracic outlet syndrome. With regard to brachial plexus impairment, pursuant to Table 15-20, page 434 of the A.M.A., *Guides,* appellant was a class zero for no impairment. For entrapment neuropathy resulting in carpal tunnel syndrome, Dr. Thompson referenced Table 15-23, page 449 of A.M.A., *Guides,* and appellant was a grade 1 modifier for an impairment rating of one percent for the right upper extremity.

OWCP requested that Dr. Thompson provide clarification of his impairment rating and provide clinical findings and test results considered in reaching his conclusion.

In a November 24, 2014 supplemental report, Dr. Thompson noted that appellant had an abnormal EMG and nerve conduction velocity (NCV) studies documenting carpal tunnel syndrome. He advised that, pursuant to the A.M.A., *Guides*, entrapment neuropathy, Table 15-23, page 449, appellant was a grade modifier 1 based on conduction delay in the EMG/NCV studies with mild intermittent symptoms and essentially normal examination as it relates to entrapment neuropathy. Dr. Thompson noted this resulted in an upper extremity impairment rating of one percent. He indicated that, under Table 15-18, carpal tunnel syndrome, pages 449 and 450, of the A.M.A., *Guides*, appellant was a grade modifier 1 as test findings on EMG/NCV studies were abnormal, her history revealed mild intermittent symptoms, but her examination was essentially within normal limits.

On March 31, 2015 OWCP referred appellant's file with a statement of accepted facts to an OWCP medical adviser. The referral letter indicated that the accepted conditions were temporary aggravation of the right arm lymphedema resolved, temporary aggravation of right carpal tunnel syndrome resolved, temporary aggravation of complex regional pain syndrome resolved, and temporary aggravation of thoracic outlet syndrome, resolved.

In a March 31, 2015 report, an OWCP medical adviser reviewed the medical evidence including Dr. Thompson's reports dated October 21 and November 24, 2014 and concurred in his findings. He noted that the date of MMI was October 21, 2014.

In a decision dated August 21, 2015, OWCP granted appellant a schedule award for one percent permanent impairment of the right hand. On November 18, 2015 it reissued the August 21, 2015 decision. The period of the award was from October 21 to November 7, 2014 for 2.44 weeks of compensation.

On December 3, 2015 counsel requested an oral hearing, which was held on March 4, 2016. He asserted that OWCP referred appellant to Dr. Penny for an impairment rating and, in his report dated June 11, 2014, he concurred with Dr. Weiss' rating of 49 percent impairment, but he failed to reference the sixth edition of the A.M.A., *Guides.* Counsel noted that, instead of requesting clarification from Dr. Penny, OWCP referred appellant to another second opinion physician, Dr. Thompson. After Dr. Thompson issued his report on October 21, 2014, OWCP subsequently wrote to Dr. Thompson for clarification and he provided a November 24, 2014 addendum. However, it did not explain why it sought clarification from Dr. Thompson, but not from Dr. Penny. Counsel further expressed disagreement with the statement of accepted facts. He indicated that appellant's claim was accepted for aggravation of right arm lymphedema, right carpal tunnel syndrome, complex regional pain syndrome/ myofascial pain syndrome, and thoracic outlet syndrome under File No. xxxxxx209 and temporary aggravation of the same conditions under File No. xxxxxx494. Counsel indicated that OWCP's referral letter to the medical adviser noted appellant's claim was only accepted for temporary aggravation of right arm lymphedema resolved, temporary aggravation of right carpal tunnel syndrome resolved, temporary aggravation of complex regional pain syndrome/ myofascial pain syndrome resolved, and temporary aggravation of thoracic outlet syndrome resolved, which was erroneous and resulted in a calculation of a rating less than representative of appellant's actual impairment. He noted that appellant's preexisting state must be factored into

the schedule award calculation. Counsel also noted that appellant's award was erroneously based on one percent impairment of the hand which resulted in a lower award while the medical adviser calculated a rating based on one percent impairment of the right arm.

In an April 29, 2016 decision, the hearing representative affirmed, as modified, the November 18, 2015 decision, finding that appellant's one percent permanent impairment was to the arm rather than the right hand.[6]

LEGAL PRECEDENT

The schedule award provision of FECA[7] and its implementing federal regulations[8] 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. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[9] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[10] For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[11]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[12] Under the sixth edition, for lower extremity impairments the evaluator identifies the impairment for the Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[13] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) +

---

[6] On September 30, 2016 OWCP issued a decision which granted appellant a schedule award for one percent permanent impairment to the right upper extremity less the prior one percent impairment to the right hand issued on November 18, 2015. This decision, however, is null and void as the Board and OWCP may not simultaneously have jurisdiction over the same case. OWCP may not issue a decision regarding the same issue on appeal before the Board, in this instance, a schedule award for right upper extremity impairment. *See Russell E. Lerman,* 43 ECAB 770, 772 (1992); *Douglas E. Billings,* 41 ECAB 880 (1990).

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] *Id.* at § 10.404(a).

[10] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (January 2010).

[11] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February2013).

[12] A.M.A., *Guides* 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[13] *Id.* at 385-419.

(GMCS - CDX).[14] The grade modifiers are used on the net adjustment formula described above to calculate a net adjustment. The final impairment grade is determined by adjusting the grade up or down the default value C, by the calculated net adjustment.[15]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical consultant for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides* with OWCP's medical consultant providing rationale for the percentage of impairment specified.[16]

OWCP procedures further provide that, when an OWCP medical adviser, second opinion specialist, or referee physician renders a medical opinion based on a SOAF which is incomplete or inaccurate, or does not use the SOAF as the framework in forming his or her opinion, the probative value of the opinion is seriously diminished or negated altogether.[17]

ANALYSIS

Appellant's claim was accepted by OWCP for aggravation of right arm lymphedema, right carpal tunnel syndrome, complex regional pain syndrome/myofascial pain syndrome, and thoracic outlet syndrome. It was later accepted for temporary aggravation of the right arm lymphedema resolved, temporary aggravation of right carpal tunnel syndrome resolved, temporary aggravation of complex regional pain syndrome resolved, and temporary aggravation of thoracic outlet syndrome, resolved.

On March 26, 2014 appellant filed a claim for a schedule award and submitted an August 20, 2013 report from Dr. Weiss, who found 49 percent permanent impairment of the right upper extremity under the A.M.A., *Guides*. Appellant's treating physician, Dr. Rutenberg, concurred in Dr. Weiss' impairment rating.

On April 8, 2014 OWCP referred appellant for a second opinion to Dr. Penny who reviewed appellant's medical history and performed a physical examination on June 11, 2014. Dr. Penny noted findings of pain with passive ROM of the right shoulder and with internal and external rotation, pain with passive ROM of the right wrist, tenderness over the right lateral epicondyle, right arm strength was 4+/5 in proximal and distal muscles, decreased light touch sensation in the entire right arm compared to the left arm with normal left upper extremity strength. Dr. Penny noted that appellant had evidence of mild carpal tunnel syndrome. He agreed with Dr. Weiss' findings that appellant had 49 percent impairment of the right arm.

OWCP procedures provide that if a second opinion report is equivocal, lacks rationale, or fails to address the specific medical issues, the claims examiner should seek clarification or

[14] *Id.* at 411.

[15] *Id*. at 387.

[16] *See supra* note 11 at Chapter 2.808.6(f) (February 2013).

[17] *Id*. at Chapter 2.809.4. *See also A.C.*, Docket No. 07-2423 (issued May 15, 2008).

further rationale from that physician.[18] It is required to seek clarification from the second opinion physician and request a supplemental report to clarify inadequacies in the initial report.[19] Only if the second opinion physician does not respond or does not provide a sufficient response after being asked should the claims examiner request scheduling with another physician.[20]

Following the receipt of Dr. Penny's report, OWCP determined that he provided nonspecific findings on examination and failed to adequately explain his impairment rating. However, it did not request a supplemental report from Dr. Penny and did not further develop the issue of whether appellant sustained permanent impairment of the right upper extremity causally related to her employment injuries. Rather, OWCP referred appellant to another second opinion physician. The Board finds that OWCP failed to properly develop the medical evidence in keeping with its procedures.

As noted, OWCP subsequently referred appellant to Dr. Thompson for another second opinion evaluation regarding appellant's claim for a schedule award for the right upper extremity due to her work injuries. In an October 21, 2014 report, Dr. Thompson opined that appellant had one percent permanent impairment of the right upper extremity for carpal tunnel syndrome under the A.M.A., *Guides*. OWCP requested that Dr. Thompson clarify his impairment rating and, in a supplemental report dated November 24, 2014, Dr. Thompson again found that appellant had one percent permanent impairment of the right arm. On March 31, 2015 an OWCP medical adviser concurred in Dr. Thompson's impairment rating.

The Board finds that OWCP failed to adequately develop the medical evidence submitted by Dr. Penny, the initial second opinion physician. Because of this, OWCP has not adequately developed appellant's claim and has not properly determined appellant's entitlement to a schedule award.[21] It is well established that proceedings under FECA are not adversarial in nature and that while the claimant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of evidence. OWCP has an obligation to see that justice is done.[22] As it failed to follow its procedures to request a supplemental report from Dr. Penny, OWCP cannot rely on Dr. Thompson's second opinion report to determine appellant's entitlement to a schedule award.[23]

The Board further finds that OWCP's medical adviser's March 31, 2015 report is also of diminished probative value as the SOAF which OWCP provided to the medical adviser was incomplete. It is well established that a physician's opinion must be based on a complete and accurate factual and medical background. When OWCP has accepted an employment condition as occurring in the performance of duty, the physician must base his opinion on the accepted

[18] *G.C.*, Docket No. 16-1109 (issued December 7, 2016); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.9(j) (June 2015).

[19] *Id.*, *see also Ayanle A. Hashi*, 56 ECAB 234 (2004).

[20] *Supra* note 17.

[21] *See G.C., supra* note 17.

[22] *John J. Carlone*, 41 ECAB 354, 358-360 (1989).

[23] *Supra* note 17.

facts.[24] On April 27, 2005 it accepted aggravation of right arm lymphedema and later expanded her claim to included right carpal tunnel syndrome, complex regional pain syndrome/myofascial pain syndrome, and thoracic outlet syndrome. On January 9, 2013 OWCP accepted temporary aggravation of the right arm lymphedema resolved, temporary aggravation of right carpal tunnel syndrome resolved, temporary aggravation of complex regional pain syndrome resolved, and temporary aggravation of thoracic outlet syndrome, resolved, in claim number xxxxxx494 which was doubled with the current claim. As it had accepted the conditions of right carpal tunnel syndrome, complex regional pain syndrome/myofascial pain syndrome, and thoracic outlet syndrome, and they were not accurately included in the SOAF, the medical adviser's opinion was based on an inaccurate SOAF.[25] The Board has held that the accepted conditions must be included in a SOAF and that when a physician renders a medical opinion based on an incomplete or inaccurate history or does not use the SOAF as the framework in forming his or her opinion, the probative value of the opinion is diminished.[26]

On remand OWCP should amend its SOAF to include all accepted conditions and refer the case back to Dr. Penny for a supplemental report to address the inadequacies in the original report. Following this and any necessary further development, OWCP shall issue a *de novo* decision.[27]

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

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

[24] *V.C.*, Docket No. 14-1912 (issued September 22, 2015).

[25] *See A.R.*, Docket No. 11-692 (issued November 18, 2011); *Willa M. Frazier*, 55 ECAB 379 (2004); *supra* note 11 at Chapter 3.600.3 (October 1990).

[26] *See S.P.*, Docket No. 14-1053 (issued October 2, 2014).

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

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated April 29, 2016 is set aside and the case remanded for further proceedings consistent with this decision.

Issued: May 23, 2017
Washington, DC

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

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board