United States Department of Labor
Employees' Compensation Appeals Board

D.K., Appellant	)	
and	)	**Docket No. 16-1387**
	)	**Issued: September 6, 2017**
U.S. POSTAL SERVICE, NETWORK DISTRIBUTION CENTER, Philadelphia, PA, 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:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 22, 2016 appellant, through counsel, timely appealed the March 22, 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 the claim.[3]

[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) (2014). 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 (2006). 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.*

[3] The case record provided to the Board includes evidence received after OWCP issued its March 22, 2016 decision. The Board is precluded from considering evidence that was not in the case record at the time OWCP rendered its final decision. 20 C.F.R. § 501.2(c)(1).

ISSUE

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

FACTUAL HISTORY

Appellant, a 53-year-old mail handler, has an accepted occupational disease claim, File No. xxxxxx161, for acquired trigger finger (right long finger) and right lateral epicondylitis, which arose on or about July 1, 2011. Additionally, under File No. xxxxxx173, OWCP previously accepted bilateral carpal tunnel syndrome, with a June 4, 2008 date of injury.[4] Appellant underwent right and left carpal tunnel releases on March 3 and April 28, 2009, respectively. She also had a right long finger trigger release on January 17, 2012, followed by a repeat right carpal tunnel release on January 24, 2012.

A February 5, 2010 cervical magnetic resonance imaging (MRI) scan revealed mild multi-level degenerative disc disease with superimposed disc protrusions at C2-3 and C3-4. To date, OWCP has not accepted an employment-related cervical condition under the current claim(s).

In July 2015, appellant filed a claim (Form CA-7) for a schedule award.

Dr. David Weiss, a Board-certified orthopedic surgeon, examined appellant on October 17, 2013, and provided a May 15, 2014 bilateral upper extremity impairment rating. He diagnosed cumulative and repetitive trauma disorder, bilateral carpal tunnel syndrome -- status post bilateral carpal tunnel releases, recurrent right carpal tunnel syndrome, bilateral flexor tenosynovitis -- status post bilateral forearm fasciotomy and flexor tenosynovectomy, chronic right elbow medial and lateral epicondylitis, and right long finger stenosing tenosynovitis -- status post trigger finger release. Dr. Weiss also diagnosed preexisting chronic cervical strain/sprain, right cervical radiculopathy (C5-6), and protruding-type cervical disc herniation (C3-4). He indicated that appellant had reached maximum medical improvement (MMI) as of October 17, 2013.

With respect to appellant's right upper extremity, Dr. Weiss found a combined nine percent impairment under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (6th ed. 2009). This included seven percent impairment for right wrist median nerve entrapment neuropathy.[5] Dr. Weiss also found one percent impairment due to a mild sensory deficit involving the right C7 nerve root.[6]

[4] OWCP combined the two above-noted upper extremity claims and designated the July 1, 2011 injury claim, File No. xxxxxx161, as the master file.

[5] *See* Table 15-23, Entrapment/Compression Neuropathy Impairment, A.M.A., *Guides* 449 (6th ed. 2009).

[6] *See* Proposed Table 1, Spinal Nerve Impairment: Upper Extremity Impairments, *The Guides Newsletter* (July/August 2009).

Additionally, he calculated one percent impairment for right elbow medial/lateral epicondylitis.[7] As noted, appellant's combined right upper extremity impairment was nine percent.[8]

Regarding appellant's left upper extremity, Dr. Weiss found spinal nerve extremity impairment involving the C5, C6, and C7 nerve roots.[9] At C5, he found a moderate sensory deficit (three percent).[10] Dr. Weiss also found mild sensory deficits at C6 (two percent) and C7 (one percent).[11] Additionally, he found eight percent impairment due to left carpal tunnel syndrome.[12] The combined left upper extremity impairment rating was 14 percent.[13]

In his May 15, 2014 report, Dr. Weiss referenced three electrodiagnostic studies (EMG/NCV) dated June 4, 2008, December 17, 2009, and June 9, 2011. The latest June 2011 study revealed mild C5-6 radiculopathy on the right and moderate carpal tunnel syndrome, bilaterally. Dr. Weiss' physical examination included Semmes-Weinstein monofilament testing that revealed diminished sensibility over the left C5, C6, and C7 dermatomes, as well as diminished sensibility over the right C7 dermatome. Monofilament testing also revealed diminished sensibility over the median nerve distribution of the left and right hands.

OWCP forwarded the case to its district medical adviser (DMA), Dr. Arnold T. Berman, a Board-certified orthopedic surgeon. In an August 3, 2015 report, Dr. Berman found eight percent impairment of the left upper extremity and nine percent impairment of the right upper extremity. The DMA disagreed with Dr. Weiss' inclusion of impairment due to cervical radiculopathy. Dr. Berman, the DMA, noted that cervical radiculopathy was not an accepted condition, and further explained that the EMG/NCV results and clinical evidence did not support Dr. Weiss' rating for cervical radiculopathy.[14] Additionally, the DMA noted that Dr. Weiss had not rated appellant for his right trigger finger condition.

The DMA essentially concurred with Dr. Weiss' right upper extremity impairment ratings for carpal tunnel syndrome (seven percent) and right elbow lateral epicondylitis (one percent). However, he omitted Dr. Weiss' one percent rating for a mild C7 sensory deficit, and found an additional one percent upper extremity impairment for digital stenosing tenosynovitis

[7] *See* Table 15-4, Elbow Regional Grid: Upper Extremity Impairments, A.M.A., *Guides* 399 (6th ed. 2009).

[8] *See* Appendix A -- Combined Values Chart, A.M.A., *Guides* 604 (6th ed. 2009).

[9] *See* Proposed Table 1, *The Guides Newsletter* (July/August 2009).

[10] *Id.*

[11] *Id.*

[12] *See* Table 15-23, A.M.A., *Guides* 449 (6th ed. 2009).

[13] *See* Appendix A, A.M.A., *Guides* 604 (6th ed. 2009).

[14] With respect to the EMG/NCV results, the DMA explained that the reported evidence of cervical radiculopathy overlapped with the carpal tunnel syndrome, which required surgery. He indicated that there was no bona fide evidence of cervical spine radiculopathy.

(trigger digit).[15] The combined right upper extremity impairment was nine percent. On the left side, the DMA similarly concurred with Dr. Weiss' eight percent rating for carpal tunnel syndrome, however, he omitted Dr. Weiss' ratings for spinal nerve extremity impairment involving the C5, C6, and C7 nerve roots. Lastly, he accepted Dr. Weiss' finding that appellant had reached MMI on October 17, 2013.

On September 22, 2015 OWCP granted a schedule award for eight percent permanent impairment of the left upper extremity and nine percent permanent impairment of the right upper extremity. The award covered a period of 53.04 weeks from October 17, 2013 through October 23, 2014. OWCP explained that it relied on the DMA's findings, which differed to some extent from Dr. Weiss' May 15, 2014 impairment rating.

Counsel timely requested a hearing, which was held before an OWCP hearing representative on January 14, 2016. At the hearing, he argued that impairment due to appellant's preexisting cervical condition should be taken into account when rating her upper extremities. Counsel also took issue with the DMA's assertion that there was inadequate clinical evidence to support Dr. Weiss' spinal nerve extremity impairment rating. He argued that OWCP should have based the September 22, 2015 schedule award on the treating physician's impairment rating. Alternatively, counsel argued that OWCP should have declared a conflict in medical opinion between Dr. Weiss and the DMA.

By decision dated March 22, 2016, the hearing representative affirmed the September 22, 2015 schedule award. While acknowledging that preexisting impairments should be taken into account, the hearing representative accepted the DMA's opinion over Dr. Weiss' May 15, 2014 impairment rating.

LEGAL PRECEDENT

FECA provides that if there is disagreement between an OWCP-designated physician and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[16] For a conflict to arise the opposing physicians' viewpoints must be of "virtually equal weight and rationale."[17] Where OWCP has referred the case to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well-reasoned and based upon a proper factual background, must be given special weight.[18]

[15] *See* Table 15-2, Digit Regional Grid, A.M.A., *Guides* 392 (6th ed. 2009). The DMA converted appellant's six percent digit (middle finger) impairment under Table 15-2 to a one percent upper extremity impairment. *See* Table 15-12, A.M.A., *Guides* 421 (6th ed. 2009).

[16] 5 U.S.C. § 8123(a); *see* 20 C.F.R. § 10.321; *Shirley L. Steib*, 46 ECAB 309, 317 (1994). The DMA, acting on behalf of OWCP, may create a conflict in medical opinion. 20 C.F.R. § 10.321(b).

[17] *Darlene R. Kennedy*, 57 ECAB 414, 416 (2006).

[18] *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

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.[19] 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. The implementing regulations have adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[20] Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[21]

Neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back/spine or the body as a whole.[22] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[23] The sixth edition of the A.M.A., *Guides* (2009) provides a specific methodology for rating spinal nerve extremity impairment.[24] It was designed for situations where a particular jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine. FECA-approved methodology is premised on evidence of radiculopathy affecting the upper and/or lower extremities. The appropriate tables for rating spinal nerve extremity impairment are incorporated in the procedure manual.[25]

When determining entitlement to a schedule award, preexisting impairment to the scheduled member should be included.[26] Impairment ratings for schedule awards include those conditions accepted by OWCP as job related, and any preexisting permanent impairment of the same member or function.[27] If the work-related injury has affected any residual usefulness in whole or in part, a schedule award may be appropriate.[28] There are no provisions for apportionment under FECA.[29] When the prior impairment is due to a previous work-related

[19] 5 U.S.C. § 8107(c). For a total or 100 percent loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1).

[20] 20 C.F.R. § 10.404.

[21] *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 (February 2013).

[22] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

[23] *Supra* note 21 at Chapter 2.808.5c(3).

[24] The methodology and applicable tables were initially published in *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July/August 2009).

[25] *See supra* note 21 at Chapter 3.700, Exhibit 4.

[26] *Carol A. Smart*, 57 ECAB 340, 343 (2006); *Michael C. Milner*, 53 ECAB 446, 450 (2002).

[27] *Supra* note 21 at Chapter 2.808.5d.

[28] *Id.*

[29] *Id.*

injury and a schedule award has been granted for such prior impairment, the percentage already paid is subtracted from the total percentage of impairment.[30]

ANALYSIS

Appellant's physician, Dr. Weiss, found 14 percent permanent left upper extremity impairment and nine percent permanent right upper extremity impairment. Both upper extremity ratings included components for spinal nerve extremity impairment. On the right side, Dr. Weiss found one percent impairment for a mild C7 sensory deficit. On the left, he found a combination of impairments for sensory deficits involving the C5 (three percent), C6 (two percent), and C7 (one percent) nerve roots. However, the DMA excluded all spinal nerve extremity impairment on the basis that appellant's cervical spine radiculopathy was not an accepted condition. Dr. Berman, the DMA, also questioned whether the objective studies and clinical evidence supported Dr. Weiss' finding of cervical radiculopathy.

As a preliminary matter, the Board notes that both Dr. Weiss and the DMA concurred with respect to appellant's right upper extremity impairment rating for carpal tunnel syndrome (seven percent) and right elbow lateral epicondylitis (one percent). The two physicians similarly concurred with regard to appellant's left upper extremity impairment for carpal tunnel syndrome (eight percent). On appeal, counsel did not challenge these aspects of the September 22, 2015 schedule award. Counsel also did not specifically challenge the DMA's finding that appellant was entitled to an additional one percent right upper extremity impairment for digital stenosing tenosynovitis (middle/long trigger finger). In his brief on appeal, counsel argued that OWCP should have accepted Dr. Weiss' finding of spinal nerve extremity impairment due to sensory deficits involving the C5 (three percent), C6 (two percent), and C7 (one percent) nerve roots. According to counsel, OWCP should have found a combined 14 percent permanent left upper extremity impairment.

The hearing representative correctly acknowledged that preexisting conditions should be taken into account when determining the full extent of impairment of a scheduled member.[31] However, in this instance Dr. Weiss' left upper extremity rating for cervical nerve root involvement is not fully supported by the record. He failed to explain how the underlying findings supported his spinal nerve extremity impairment rating. Counsel noted that Dr. Weiss' May 15, 2014 report included monofilament testing results that ostensibly support his findings with respect to left-sided C5, C6, and C7 nerve root sensory deficits. However, Dr. Weiss did not explain how the reported "diminished sensibility" over the left C5, C6, and C7 dermatomes represented a moderate sensory deficit at C5 and mild sensory deficits at C6 and C7. He also reviewed various EMG/NCV results. While he noted there was "positive" evidence of right cervical radiculopathy at C5-6, Dr. Weiss did not identify any electrodiagnostic evidence of left-sided cervical radiculopathy. Accordingly, the Board finds that the record does not adequately support Dr. Weiss' additional six percent rating for spinal nerve extremity impairment. Thus, appellant has no more than eight percent permanent impairment of the left upper extremity.

[30] *Id.* at Chapter 2.808.7a(1); 20 C.F.R. § 10.404(c).

[31] *See supra* note 27.

CONCLUSION

The Board finds that appellant failed to establish that she has greater than eight percent impairment of the left upper extremity, for which she previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the March 22, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 6, 2017
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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