United States Department of Labor
Employees' Compensation Appeals Board

K.S., Appellant	)	
	)	
and	)	**Docket No. 17-1663**
	)	**Issued: March 28, 2018**
U.S. POSTAL SERVICE, ATLANTA NDC, Atlanta, GA, 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
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 26, 2017 appellant filed a timely appeal from an April 20, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP).[1] 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.[3]

[1] Appellant timely requested oral argument before the Board. By order dated January 18, 2018, the Board exercised its discretion and denied the request, finding that the arguments on appeal could adequately be addressed based on the case record. *Order Denying Request for Oral Argument*, Docket No. 17-1663 (issued January 18, 2018).

[2] 5 U.S.C. § 8101 *et seq.*

[3] The Board notes that appellant submitted additional evidence with his appeal to the Board. The Board's jurisdiction is limited to the evidence that was before OWCP at the time it issued its final decision. Therefore, the Board is precluded from considering this additional evidence for the first time on appeal. 20 C.F.R. § 501.2(c)(1); *P.W.*, Docket No. 12-1262 (issued December 5, 2012).

ISSUE

The issue is whether appellant has established that she has more than five percent permanent impairment of her right upper extremity and five percent permanent impairment of her left upper extremity, for which she previously received schedule awards.

FACTUAL HISTORY

On February 18, 2011 appellant, then a 59-year-old mail handler, filed an occupational disease claim (Form CA-2) alleging that her employment duties caused cubital tunnel syndrome.[4] OWCP accepted bilateral cubital tunnel syndrome. Appellant had stopped work on December 1, 2010 and did not return. OWCP paid her wage-loss compensation beginning February 19, 2011, and placed her on the periodic compensation rolls in March 2011.

Dr. Stephen M. McCollam, Board-certified in orthopedic and hand surgery, performed left cubital tunnel release on March 14, 2011. On June 13, 2011 he performed cubital tunnel release on the right. On October 11, 2011 Dr. McCollam reported that appellant had reached maximum medical improvement (MMI). He provided permanent restrictions and advised that appellant had six percent permanent impairment of each extremity under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[5]

Appellant retired on disability, effective June 25, 2012. On August 2, 2012 she filed a schedule award claim (Form CA-7).

On August 29, 2012 OWCP noted that only left cubital tunnel had been accepted and asked its medical adviser to provide an impairment evaluation. In an August 29, 2012 report, an OWCP medical adviser noted that Dr. McCollam's impairment rating was not in accordance with the A.M.A., *Guides*. The medical adviser indicated that, in accordance with Table 15-23 of the sixth edition of the A.M.A., *Guides*, appellant had zero percent impairment of the left upper extremity.

On November 13, 2012 appellant elected Civil Service Retirement System benefits, effective that day.

By decision dated November 20, 2012, OWCP noted that appellant had previously received a schedule award for five percent permanent impairment of her left upper extremity under File No. xxxxxx846. It found the weight of the medical evidence rested with its medical adviser and denied appellant's current schedule award claim.

[4] The record indicates that appellant had originally filed a claim for recurrence of disability (Form CA-2a) under OWCP File No. xxxxxx846, which was accepted for bilateral carpal tunnel syndrome. Under that claim, by decision dated July 6, 2001, OWCP granted appellant a schedule award for five percent permanent impairment of her right upper extremity and five percent permanent impairment of her left upper extremity. OWCP determined that the cubital tunnel syndrome claim was a new occupational disease, to be adjudicated separately under File No. xxxxxx845. OWCP has not administratively combined the case records.

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

Appellant timely requested a hearing before an OWCP hearing representative on December 18, 2012. On February 5, 2013 her then counsel requested that the hearing request be changed to a review of the written record.[6] In a March 15, 2013 decision, an OWCP hearing representative affirmed the November 20, 2012 decision.

On August 18, 2014 Dr. Daniel Sohn, a Board-certified orthopedic surgeon, performed left cubital tunnel subcutaneous ulnar nerve transposition. On August 29, 2014 he performed revision of the subcutaneous ulnar nerve on the right, due to recurrent right cubital tunnel syndrome.[7]

Appellant again filed a schedule award claim on September 1, 2015. She submitted an October 21, 2015 report in which Dr. Jeffrey Kesten, Board-certified in physical medicine and rehabilitation and pain medicine, described her medical and surgical history. Dr. Kesten provided examination findings including active range of motion of both elbows. Sensory examination was compromised to soft touch, right greater than left. Dr. Kesten advised that appellant had reached MMI and, in accordance with the sixth edition of the A.M.A., *Guides*, under Table 15-21, peripheral nerve impairment of the upper extremity, she had a class 1 impairment for right cubital peripheral ulnar nerve impairment of each upper extremity.

On February 17, 2016 Dr. Kesten performed an upper extremity electromyogram and nerve conduction velocity (EMG/NCV) study which he indicated was consistent with severe right ulnar neuropathy at the elbow (*i.e.*, cubital tunnel syndrome) involving sensory and motor distributions with a minimal amount of associated denervation. Left ulnar findings were likely resultant of postoperative changes and not reflective of ongoing pathology. The study also demonstrated findings consistent with left greater than right carpal tunnel syndrome affecting the sensory distributions without associated denervation. No evidence of cervical radiculopathy, brachial plexopathy, peripheral polyneuropathy, or myopathy was seen.

On March 22, 2016 OWCP asked its medical adviser to review the medical record for schedule award purposes. In a March 28, 2016 report, Dr. Michael M. Katz, a Board-certified orthopedic surgeon and OWCP medical adviser, noted his review of the record including that appellant received prior schedule awards of five percent impairment of each upper extremity. He advised that, while Dr. Kesten utilized Table 15-21 of the A.M.A., *Guides* in his impairment calculation, he should have used Table 15-23, Entrapment Neuropathy. Dr. Katz indicated that upon his review of the record including Dr. Kesten's February 17, 2016 EMG/NCV study, due to ulnar nerve entrapment, for the right upper extremity, appellant had a grade modifier of 3 for test findings, 2 for physical examination due to decreased sensation, and 2 for history of significant intermittent symptom. He followed the procedure found in Table 15-23 and averaged the modifiers to 2, which yielded a range of impairment of four to six percent. Dr. Katz indicated that a functional scale was not assigned and selected the default value of class 1, for five percent right upper extremity permanent impairment. For the left upper extremity, he assigned modifiers of 2 to test findings, physical examination, and history, for an average of 2. Dr. Katz again noted that functional scale was not assigned, and concluded that appellant had five percent permanent

[6] At that time appellant was represented by Paul H. Felser, Esquire.

[7] Appellant had relocated from Georgia to Michigan. In September 2015 she moved to Colorado.

impairment of the left upper extremity. He indicated that appellant reached MMI on October 21, 2015, the date of Dr. Kesten's examination.

Dr. Kesten provided a November 21, 2016 right upper extremity impairment rating with an attached *Quick*DASH (Disabilities of the Arm, Shoulder and Hand) assessment of 97.7. He identified both the ulnar and median nerves and found that, in accordance with Table 15-23, for ulnar nerve impairment, appellant had modifiers of 3 each for test findings, history, and physical findings, and also a functional scale of 3, based on appellant's *Quick*DASH score. Dr. Kesten concluded that appellant had nine percent right upper extremity ulnar nerve impairment. For median nerve impairment, he found a modifier of 2 for test findings, and 3 each for history and physical findings, and also a functional scale of 3, based on appellant's *Quick*DASH score. He concluded that appellant had six percent right upper extremity median nerve impairment. Dr. Kesten then utilized the Combined Values Chart and concluded that appellant had 12 percent right upper extremity permanent impairment.

OWCP determined that a conflict in medical opinion evidence had been created between treating physician Dr. Kesten and Dr. Katz, its medical adviser. In February 2017 it referred appellant to Dr. Alfred Lotman, a Board-certified orthopedic surgeon for an impartial medical evaluation.[8] OWCP forwarded a copy of the statement of accepted facts (SOAF) which noted that appellant's claim was accepted for bilateral cubital tunnel syndrome.

Dr. Kesten continued to submit treatment notes but did not provide an additional impairment evaluation.

In an April 11, 2017 report, Dr. Lotman noted his review of the SOAF and medical record. He described appellant's current complaints of bilateral upper extremity pain, more severe on the right, which restricted activities of daily living and necessitated aid in personal hygiene. No gross muscle atrophy or skin changes were seen on physical examination. Dr. Lotman opined that appellant exhibited significant pain behaviors, noting that strength testing with dynamometer had to be discontinued due to her complaints of severe pain. Tinel's signs were present at both elbows and absent at both wrists. Dr. Lotman indicated that sensation to light touch changed during repeated sensory testing, and that two-point discrimination was not reliable. Range of motion of the cervical spine was normal, and no central nervous system findings were found. Regarding right upper extremity impairment, Dr. Lotman noted that under Table 15-21 appellant had cubital tunnel syndrome. He then referred to Table 15-23 and assigned a modifier of 3 for test findings, and 2 each for physical findings and history. Dr. Lotman noted that he went over appellant's *Quick*DASH score with her and advised that, based on his objective findings and appellant's subjective complaints, he would not assign a functional scale impairment. He concluded that appellant, therefore, had five percent permanent impairment of the right upper extremity. Regarding left upper extremity impairment, Dr. Lotman assigned modifiers of 2 each to test findings, physical findings, and history and applied the same reasoning noted above for not assigning a functional scale impairment. He concluded that appellant also had five percent permanent impairment of the left upper extremity. Dr. Lotman noted his agreement with Dr. Katz that appellant had five percent permanent impairment of each upper extremity and, as appellant

[8] An OWCP appointment schedule notification form (OWCP ME023) and bypass log are found in the record.

had previously received schedule awards for five percent each, she was not entitled to an increased award.

By merit decision dated April 20, 2017, OWCP found that the special weight of the medical evidence rested with the opinion of Dr. Lotman who provided an impartial evaluation and concluded that appellant was not entitled to an additional schedule award for upper extremity permanent impairment.

LEGAL PRECEDENT

The schedule award provisions of FECA, and its implementing federal regulations, 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.[9] FECA, however, does not specify the manner in which the percentage of loss shall be determined. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by OWCP as a standard for evaluation of scheduled losses, and the Board has concurred in such adoption.[10] For decisions issued after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[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, the evaluator identifies the impairment for the Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History, Physical Examination, and Clinical Studies. The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[13] Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnosis from regional grids and calculations of modifier scores.[14]

Impairment due to carpal tunnel syndrome and cubital tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text in section 15.4f of the A.M.A., *Guides*.[15] In Table 15-23, grade

[9] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[10] 20 C.F.R. § 10.404; *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

[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 (February 2013).

[12] A.M.A., *Guides*, *supra* note 5 at 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

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

[14] *See R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[15] A.M.A., *Guides*, *supra* note 5 at 433-50.

modifiers levels (ranging from 0 to 4) are described for the categories test findings, history, and physical findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating value may be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities.[16]

The A.M.A., *Guides* specifically indicate that, if multiple simultaneous neuropathies occur in the same limb, both impairments may be rated, and the nerve qualifying for the larger impairment is given the full impairment while the nerve qualifying for the smaller impairment is rated at 50 percent.[17] The A.M.A., *Guides* further indicate that Table 15-23 is to be used for rating focal nerve compromise,[18] and Appendix 15-B provides further guidance regarding electrodiagnostic evaluation of entrapment syndromes.[19]

Section 8123(a) of FECA provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[20] The implementing regulation states that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination, and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[21] When there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[22]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[23]

[16] *Id*. at 448-50.

[17] *Id*. at 448.

[18] *Id*.

[19] *Id*. at 487-90.

[20] 5 U.S.C. § 8123(a); *see Y.A.*, 59 ECAB 701 (2008).

[21] 20 C.F.R. § 10.321.

[22] *V.G.*, 59 ECAB 635 (2008).

[23] *See* Federal (FECA) Procedure Manual, *supra* note 11 at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

ANALYSIS

The Board finds this case is not in posture for decision. Under the instant claim, File No. xxxxxx845, OWCP accepted bilateral cubital tunnel syndrome. Under a previous claim, File No. xxxxxx846, it accepted bilateral carpal tunnel syndrome. On July 6, 2001 OWCP granted appellant a schedule award for five percent permanent impairment of each upper extremity under File No. xxxxxx846.

While OWCP has some discretion to determine whether case files should be doubled,[24] its procedures provide that cases should be doubled when correct adjudication of the issues depends on frequent cross-reference between files including when a new injury is reported for an employee who previously filed an injury claim for a similar condition or the same part of the body and should be doubled as soon as the need to do so becomes apparent.[25] As referenced above, for schedule award purposes, if multiple simultaneous neuropathies occur in the same limb, both impairments may be rated.[26] OWCP has accepted bilateral cubital tunnel syndrome under File No. xxxxxx845 and bilateral carpal tunnel syndrome under File No. xxxxxx846 and, both upper extremity conditions. As the cases have not been administratively doubled, the record before the Board is incomplete and would not permit an informed adjudication by the Board regarding the degree of appellant's upper extremity impairments. Therefore, the case must be remanded for OWCP to combine File No. xxxxxx846 and File No. xxxxxx845.

The Board further finds that the case must be remanded because none of the physicians who provided impairment evaluations followed procedures outlined in the A.M.A., *Guides* regarding multiple simultaneous neuropathies or explained why this analysis would not be applicable. The A.M.A., *Guides* specifically indicate that, if multiple simultaneous neuropathies occur in the same limb, both impairments may be rated, and the nerve qualifying for the larger impairment is given the full impairment while the nerve qualifying for the smaller impairment is rated at 50 percent.[27] On remand OWCP should ask Dr. Lotman, the referee physician, for a supplemental opinion determining whether appellant would be entitled to an increased award for multiple simultaneous neuropathies.[28]

The Board also notes that OWCP procedures provide that, if a case has been referred for a referee impairment evaluation, the case should be referred to its medical adviser who has not previously reviewed the record. OWCP's medical adviser should not resolve the conflict of medical opinion or attempt to clarify or expand the opinion of the referee, but is to review the

[24] *See M.R.*, Docket No. 06-0198 (issued August 28, 2006).

[25] Federal (FECA) Procedure Manual, *supra* note 11 at Part 2 -- Claims, *File Maintenance and Management*, Chapter 2.400.8c (February 2000).

[26] A.M.A., *Guides*, *supra* note 5 at 448.

[27] *Id*. at 448.

[28] *See C.A.*, Docket No. 17-0665 (issued November 8, 2017).

referee's report for proper application of the A.M.A., *Guides*.[29] OWCP did not refer Dr. Lotman's report to an OWCP medical adviser for review. Upon receipt of Dr. Lotman's supplementary report, OWCP should refer the report to an appropriately selected medical adviser for review.

Following the further development described above and such other development as may be deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim for an additional schedule award for bilateral upper extremity impairment.

CONCLUSION

The Board finds this case not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the April 20, 2017 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision of the Board.

Issued: March 28, 2018
Washington, DC

Patricia H. Fitzgerald, Deputy 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

[29] Federal (FECA) Procedure Manual, *supra* note 11 at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 6.g (February 2013).