United States Department of Labor
Employees' Compensation Appeals Board

R.W., Appellant	)	
and	)	**Docket No. 23-0390**
	)	**Issued: April 11, 2024**
U.S. POSTAL SERVICE, CARDISS COLLINS POST OFFICE, Chicago, IL, Employer	)	

Appearances:
Alan J. Shapiro, *Esq.*, for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 24, 2023 appellant, through counsel, filed a timely appeal from a January 5, 2023 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.

[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.*

ISSUE

The issue is whether appellant has met her burden of proof to establish greater than four percent permanent impairment of the left upper extremity, for which she previously received schedule award compensation.

FACTUAL HISTORY

On July 31, 2009 appellant, then a 43-year-old machine operator, filed an occupational disease claim (Form CA-2) alleging that she developed right wrist tendinitis due to factors of her federal employment including the repetitive movements that she had performed for the past 19 years. She noted that she first became aware of her claimed condition on April 28, 2009, and realized its relationship to her federal employment on May 29, 2009. Appellant stopped work on April 28, 2009. OWCP accepted the claim for bilateral wrist/forearm tendonitis. By decision dated February 9, 2010, it expanded the acceptance of appellant's claim to include bilateral de Quervain's disease, bilateral carpal tunnel syndrome, and bilateral cubital tunnel syndrome. OWCP paid her wage-loss compensation on the supplemental rolls, effective April 28, 2009, and on the periodic rolls, effective March 14, 2010.

Appellant underwent OWCP-authorized left wrist tenosynovectomy/tendon debridement surgery on February 26, 2010 and left wrist open repair surgery on September 20, 2010.

On June 29, 2011 OWCP granted appellant a schedule award for two percent permanent impairment of each upper extremity. The award ran for 12.48 weeks from June 15 through September 10, 2011 and was based on the June 13, 2011 report of Dr. David H. Garelick, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA).

By decision dated September 9, 2013, OWCP granted appellant a schedule award for additional two percent permanent impairment of each upper extremity (the arms). The award ran for 12.48 weeks from August 25 through November 20, 2013.

On January 8, 2020 appellant underwent OWCP-approved left carpal and left cubital tunnel release surgeries, as well as release of the first dorsal compartment of the left wrist for de Quervain's tendinitis.

On September 28, 2021 appellant filed a claim for compensation (Form CA-7) for an additional schedule award.

In an October 8, 2021 development letter, OWCP requested that appellant's treating physician submit an impairment evaluation report in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3] It afforded her 30 days to submit additional medical evidence in support of her increased schedule award claim.

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

Appellant submitted a September 30, 2021 impairment rating report by Dr. Neil Allen, a Board-certified neurologist and internist. Dr. Allen noted diagnosed conditions of bilateral tenosynovitis of the hand and wrist, bilateral radial styloid tenosynovitis, bilateral lesion of the ulnar nerve, bilateral carpal tunnel syndrome, ganglion of the joint, pathologic fracture of the left distal radius and ulna, and other disorder of the right synovium and tendon. He reviewed appellant's history of injury and indicated that she underwent left wrist surgery and left carpal tunnel and cubital tunnel release surgeries. On physical examination of her left elbow, Dr. Allen observed no tenderness and diminished touch over the anterior forearm. He performed three range of motion (ROM) measurements for appellant's left elbow and noted 141, 149, and 148 degrees of flexion, -1, 5, and 6 degrees of extension, 72, 73, and 71 degrees of supination, and 86, 87, and 90 degrees of pronation. Examination of appellant's left wrist and hand revealed no tenderness to palpation and intact discrimination and radial impulses. ROM measurements performed three times for the left wrist revealed 58, 61, and 65 degrees of flexion, 68, 65, and 59 degrees of extension, 24, 30, and 31 degrees of radial deviation, and 45, 48, and 50 degrees of ulnar deviation.

Referencing the sixth edition of the A.M.A., *Guides*, Dr. Allen utilized the diagnosis-based impairment (DBI) rating method and determined that, under Table 15-4 (Elbow Regional Grid), page 398, the class of diagnosis (CDX) for elbow pain resulted in a Class 1 impairment with a default value of one percent. He assigned a grade modifier for physical examination (GMPE) of 0 and a grade modifier for clinical studies (GMCS) of 0. Dr. Allen noted that a grade modifier for functional history (GMFH) was not applicable. He applied the net adjustment formula, (0 - 1) + (0 - 1) = -2, and calculated that appellant had zero percent permanent impairment of the left elbow. Referencing Table 15-3 (Wrist Regional Grid), page 395, Dr. Allen indicated that the CDX for wrist laceration or ruptured tendon resulted in a Class 1 impairment with a default value of five percent. He assigned a GMPE of 0 and reported that grade modifiers of GMCS and GMFH were not applicable. After applying the net adjustment formula, (0 - 1) = -1, Dr. Allen calculated that appellant had four percent permanent impairment for the left wrist. He concluded that she had a total left upper extremity permanent impairment of four percent.

OWCP referred appellant's claim to Dr. Todd Fellars, a Board-certified orthopedic surgeon serving as the DMA, to review the medical evidence of record, including Dr. Allen's September 30, 2021 report, and requested that he provide an opinion on the permanent impairment of her left upper extremity under the sixth edition of the A.M.A., *Guides*.

In an April 11, 2022 report, Dr. Fellars indicated that he had reviewed Dr. Allen's September 30, 2021 impairment rating report and advised that he "agreed with [Dr. Allen's] assessment." He utilized the DBI rating method to find that, under Table 15-4 (Elbow Regional Grid), page 398, appellant had a CDX of 1 for elbow pain, which resulted in a default value of one percent. Dr. Fellars assigned a GMFH of 3, a GMPE of 0, and a GMCS of 0. He indicated that the net adjustment resulted in -2, which equaled zero percent permanent impairment for the left elbow. Referencing Table 15-3 (Wrist Regional Grid), page 395, Dr. Fellars reported that appellant had a CDX of 1 for lacerated tendon, which resulted in a default value of five percent. He assigned a GMFH of 3, but explained that, since it was two classes greater than the GMPE, it was not applicable. Dr. Fellars noted a GMPE of 0 and indicated that a GMCS was not applicable. He indicated that the net adjustment was -1, which resulted in four percent permanent impairment of the left wrist. Dr. Fellars reported that the four percent permanent impairment of the left upper extremity was the "total impairment present" and "would not be awarded in addition to any

previously paid impairment." He further explained that both ROM and DBI rating methods had been assessed and the DBI rating method was greater. Dr. Fellars noted a date of maximum medical improvement (MMI) of September 30, 2021.

By decision dated June 25, 2022, OWCP denied appellant's claim for an increased schedule award. It found that the medical evidence of record was insufficient to establish greater than four percent permanent impairment of the left upper extremity previously awarded.

On July 15, 2022 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review, which was held on November 17, 2022.

By decision dated January 5, 2023, OWCP's hearing representative affirmed the June 25, 2022 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA[4] and its implementing regulations[5] 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. FECA, however, does not specify the manner in which the percentage of loss of a member 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 and the Board has concurred in such adoption.[6] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, published in 2009, is used to calculate schedule awards.[7]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated. Under the DBI rating method, the sixth edition requires identifying the CDX, which is then adjusted by the GMFH, GMPE, and GMCS.[8] The net adjustment formula is (GMFH) – (CDX) + (GMPE – CDX) + (GMCS – CDX).[9] Under Chapter 2.3, evaluators are directed to

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id.* at § 10.404(a); *see also T.T.*, Docket No. 18-1622 (issued May 14, 2019); *Jacqueline S. Harris*, 54 ECAB 139 (2002).

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); *see also id.* at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[8] A.M.A., *Guides* 494-531.

[9] *Id.* at 521.

provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[10]

The A.M.A., *Guides* also provide that the ROM impairment is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other diagnosis-based sections are applicable.[11] If ROM is used as a stand-alone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are measured and added.[12] Adjustments for functional history may be made if the evaluator determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[13]

Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides:

> "As the [A.M.A.,] *Guides* caution that, if it is clear to the evaluator evaluating loss of ROM that, a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s).
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> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify (1) the methodology used by the rating physician (*i.e.* DBI or ROM) and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the [A.M.A.,] Guides allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used.*" (Emphasis in the original.)[14]
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> The Bulletin further advises:
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> "If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* allows for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE."[15]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's DMA for an opinion concerning the nature and percentage of

[10] *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[11] A.M.A., *Guides* 461.

[12] *Id.* at 473.

[13] *Id.* at 474.

[14] FECA Bulletin No. 17-06 (issued May 8, 2017).

[15] *Id.*

impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[16]

It is well established that benefits payable under 5 U.S.C. §8107(c) are reduced by the period of compensation paid under the schedule for an earlier injury if: (1) compensation in both cases is for impairment of the same member or function or different parts of the same member or function; and (2) the latter impairment in whole or in part would duplicate the compensation payable for the preexisting impairment.[17]

ANALYSIS

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

Appellant submitted a September 30, 2021 impairment rating report, wherein Dr. Allen, reviewed appellant's history of injury and noted her diagnosed conditions. Dr. Allen provided examination findings, including three ROM measurements for her left elbow and wrist. He utilized the DBI rating method and determined that appellant had zero percent permanent impairment for the left elbow and four percent permanent impairment for the left wrist.

In an April 11, 2022 report, Dr. Fellars, the DMA, indicated that he agreed with Dr. Allen's September 30, 2021 impairment rating. He utilized the DBI rating method to find that, under Table 15-4 (Elbow Regional Grid), page 398 of the sixth edition of the A.M.A., *Guides*, appellant had a CDX for elbow pain, which resulted in a Class 1 impairment with a default value of one percent. Dr. Fellars assigned a GMFH of 3, a GMPE of 0, and a GMCS of 0; applied the net adjustment formula; and determined that she had zero percent permanent impairment of the left elbow. Referencing Table 15-3 (Wrist Regional Grid), page 395, he reported that appellant had a CDX of 1 for lacerated tendon, which resulted in a default value of five percent. Dr. Fellars assigned a GMPE of 0 and calculated that she had four percent permanent impairment for the left wrist. He reported that the four percent permanent impairment of the left upper extremity was the "total impairment present" and "would not be awarded in addition to any previously paid impairment." Dr. Fellars further explained that both ROM and DBI rating methods had been assessed and the DBI rating method was greater.

As noted above, FECA Bulletin No. 17-06 provides that, if the rating physician provided an assessment using the ROM method and the A.M.A., *Guides* allows for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating.[18] In this case, Dr. Fellars provided a rating using the DBI rating method for the diagnoses of elbow pain in Table 15-4 (Elbow Regional Grid) and wrist laceration or ruptured tendon in Table 15-3 (Wrist Regional Grid). He did not, however, provide calculations or an impairment rating using the ROM methodology under Table 15-32,

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[16] *See supra* note 7 at Chapter 2.808.6f (March 2017). *R.M.*, Docket No. 18-1313 (issued April 11, 2019); *C.K.*, Docket No. 09-2371 (issued August 18, 2010).

[17] 20 C.F.R. § 10.404(d); *see S.M.*, Docket No. 17-1826 (issued February 26, 2018); *T.S.*, Docket No. 16-1406 (issued August 9, 2017); *T.S.*, Docket No. 09-1308 (issued December 22, 2009).

[18] *Supra* note 15.

page 473, even though the diagnoses of elbow pain and wrist laceration or ruptured tendon allows for the alternate method of rating impairment under the ROM method.[19] Accordingly, Dr. Fellars' opinion does not conform to the A.M.A., *Guides* and is of diminished probative value regarding the degree of appellant's left upper extremity permanent impairment.

Furthermore, Dr. Fellars did not sufficiently explain why appellant was not entitled to an increased schedule award for her left upper extremity. The Board has held that simply comparing the prior percentage of permanent impairment awarded to the current impairment for the same member is not always sufficient to deny an increased schedule award claim.[20] The issue is not whether the current permanent impairment rating is greater than the prior impairment ratings, but whether it duplicates in whole or in part the prior impairment rating.[21] Dr. Fellars did not address the previous schedule award, nor did he explain whether her current left upper extremity impairment rating duplicated the prior left upper extremity impairment rating.[22]

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter.[23] While the claimant has the responsibility to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence. It has the obligation to see that justice is done.[24] As OWCP undertook development of the evidence, it had an obligation to do a complete job and obtain a proper evaluation and report that would resolve the issue in this case.[25]

The case shall, therefore, be remanded for the DMA, Dr. Fellars, to provide an impairment rating utilizing the ROM rating method. He should also be instructed to address appellant's previous schedule award and explain whether her current left upper extremity impairment rating duplicated the prior left upper extremity impairment rating. Following this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

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[19] *See D.C.*, Docket No. 22-0961 (issued January 20, 2023); *H.C.*, Docket No. 21-0761 (issued May 5, 2022); *V.G.*, Docket No. 20-0455 (issued June 17, 2021).

[20] *See D.P.*, Docket No. 19-1514 (issued October 21, 2020); *S.M.*, Docket No. 17-1826 (issued February 26, 2018).

[21] *Id.*

[22] *M.F.*, Docket No. 20-1434 (issued April 26, 2021).

[23] *N.L.*, Docket No. 19-1592 (issued March 12, 2020); *M.T.*, Docket No. 19-0373 (issued August 22, 2019); *B.A.*, Docket No. 17-1360 (issued January 10, 2018).

[24] *S.S.*, Docket No. 18-0397 (issued January 15, 2019); *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

[25] *G.M.*, Docket No. 19-1931 (issued May 28, 2020); *W.W.*, Docket No. 18-0093 (issued October 9, 2018).

ORDER

IT IS HEREBY ORDERED THAT the January 5, 2023 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: April 11, 2024
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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