United States Department of Labor
Employees' Compensation Appeals Board

G.R., Appellant	)	
and	)	**Docket No. 24-0791**
	)	**Issued: October 28, 2024**
DEPARTMENT OF JUSTICE, FEDERAL BUREAU OF PRISONS, FEDERAL CORRECTIONAL COMPLEX, Beaumont, TX, 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
JANICE B. ASKIN, Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On July 29, 2024 appellant filed a timely appeal from a July 16, 2024 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[1]

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 10 percent permanent impairment of the right upper extremity, for which he previously received schedule award compensation.

[1] The Board notes that, following the July 16, 2024 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id*.

FACTUAL HISTORY

On July 14, 2003 appellant, then a 34-year-old senior officer, filed a traumatic injury claim (Form CA-1) alleging that on July 13, 2003 he injured his right hand while in the performance of duty. He indicated that while restraining an inmate, he fell to the ground and jammed his right hand and wrist into concrete. Appellant stopped work on July 14, 2003 and returned to full-duty work on March 17, 2004. OWCP accepted the claim for right carpal tunnel syndrome (CTS) and right wrist contusion. It paid appellant wage-loss compensation on the supplemental rolls from February 2 through 21, 2004 and on the periodic rolls from February 22 through March 20, 2004.

A November 7, 2003 electromyography and nerve conduction velocity (EMG/NCV) study revealed severe focal entrapment neuropathy of the right median nerve at the wrist, or CTS.

On March 4, 2004 appellant underwent an OWCP-authorized right endoscopic carpal tunnel release surgery by Dr. Robert C. Kramer, a Board-certified orthopedic hand surgeon.

On March 12, 2009 appellant underwent an OWCP-authorized A1 pully release of the right index and middle fingers by Dr. Kramer to address stenosing tenosynovitis.

By decision dated November 10, 2010, OWCP granted appellant a schedule award for two percent permanent impairment of the right upper extremity. The award ran for 6.24 weeks from July 21 through September 2, 2010.

In a May 9, 2022 report, Dr. James J. Jackson, Board-certified in physiatry, noted that appellant complained of pain in the right thumb, middle, and ring fingers with worsening grip strength and hand numbness on the right. He performed a physical examination and diagnosed right wrist contusion and CTS. Dr. Jackson indicated that he performed EMG/NCV studies of the right and left upper extremities on that date.

In a May 9, 2022 impairment evaluation, Dr. John W. Ellis, a Board-certified family medicine specialist, documented appellant's complaints and physical examination findings and diagnosed right wrist contusion and right-sided CTS. He opined that he had reached maximum medical improvement (MMI) as of that date. Dr. Ellis applied the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[2] and indicated that, using the range of motion (ROM) method, appellant had 56 percent permanent impairment of the right upper extremity based upon combined impairment values for the wrist, thumb, index finger and middle finger.

On June 7, 2022 appellant filed a claim for compensation (Form CA-7) for an increased schedule award.

On October 10, 2022 Dr. Todd Fellars, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), reviewed a statement of accepted facts (SOAF) and the medical record. He disagreed with Dr. Ellis' methodology and impairment rating. Dr. Fellars recommended a second opinion examination.

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

On November 1, 2022 OWCP referred appellant, a SOAF, the medical record, and a series of questions, to Dr. Vinod Panchbhavi, a Board-certified orthopedic surgeon, for a second opinion examination and impairment rating evaluation.

In a November 17, 2022 report, Dr. Panchbhavi diagnosed right wrist contusion and right-sided CTS. He performed a physical examination, which revealed mildly decreased sensation in the right median nerve distribution, tenderness to palpation of the right wrist, negative Finkelstein, Phalen, and Tinel's signs on the right, and no evidence of thenar or hypothenar muscle wasting, triggering, or forearm/biceps atrophy. Dr. Panchbhavi measured ROM of the wrists three times and found on the right, 10, 15, and 17 degrees of flexion; 30, 35, and 33 degrees of extension; 10, 15 and 10 degrees of ulnar deviation; and 10, 5, and 10 degrees of radial deviation. He opined that appellant had reached MMI on November 17, 2022, the date of his evaluation. Dr. Panchbhavi referenced the sixth edition of the A.M.A., *Guides* and, using Table 15-23 (Entrapment/ Compression Neuropathy Impairment), page 449, found six percent right upper extremity impairment.

In a February 16, 2023 narrative report, Dr. Ellis disagreed with Dr. Panchbhavi's impairment rating. He noted that Dr. Panchbhavi was not provided with the May 9, 2022 EMG/NCV study performed by Dr. Jackson, which he indicated revealed electrophysiological evidence of chronic median neuropathies at the wrists suggestive of severe bilateral CTS. Dr. Ellis amended his permanent impairment rating to reflect 34 percent permanent impairment of the right upper extremity due to peripheral nerve impairment and 56 percent permanent impairment based upon the ROM method, which he indicated resulted in a combined value impairment of 71 percent of the right upper extremity.

On March 2, 2023 OWCP forwarded the November 17, 2022 report of Dr. Panchbhavi and the February 16, 2023 report of Dr. Ellis to Dr. Fellars, serving as DMA, for a supplemental report.

In a March 14, 2023 report, Dr. Fellars opined that Dr. Ellis' February 16, 2023 report did not contain sufficient detail to permit assignment of an impairment rating in accordance with the A.M.A., *Guides*, and that his permanent impairment rating of 71 percent of the right upper extremity was not sufficiently explained or supported by documented examination findings.

In an April 14, 2023 medical report, Dr. Marcos V. Masson, a Board-certified orthopedic hand surgeon, noted his examination findings and that appellant had a prior history of type II diabetes.

OWCP thereafter received a May 9, 2022 report of an EMG/NCV study of the upper extremities, which revealed evidence of chronic bilateral median neuropathies suggestive of severe CTS.

In a May 11, 2023 narrative report, Dr. Ellis again amended his opinion and provided an impairment rating of 74 percent of the right upper extremity under the sixth edition of the A.M.A., *Guides*. He indicated that he applied section 15.4 (Peripheral Nerve Impairment), page 219, which resulted in 34 percent right upper extremity impairment for "the peripheral nerve injury." Dr. Ellis also noted that he applied Figure 15-13 (Upper Extremity Range of Motion Record), page 462, and Table 15-11 (Impairment Values Calculated from Upper Extremity Impairment), page 420, which resulted in 61 percent impairment of the right upper extremity for range of motion deficits

in the hand, including the thumb, index, and middle fingers, and wrist. He then combined those ratings and found 74 percent permanent impairment of the right upper extremity.

In a letter dated June 15, 2023 letter, Dr. Masson requested that OWCP authorize an updated EMG/NCV study of the right upper extremity.

On November 3, 2023 OWCP referred appellant, a SOAF, the medical record, and a series of questions to Dr. Charles F. Xeller, a Board-certified orthopedic surgeon, for a second opinion examination and impairment rating evaluation.

On January 22, 2024 OWCP received a December 28, 2023 report of EMG/NCV study of the cervical spine and bilateral upper extremities, which revealed moderate sensory-motor, distal, diffused, mostly demyelinating, diabetic, peripheral polyneuropathy of the bilateral upper extremities; right lower cervical subacute chronical cervical radiculopathy at C7 and C8 with mild active denervation, chronic neurogenic changes, and reinnervation; and no evidence of myopathy, plexopathy, or neuromuscular junction disorder of the bilateral upper extremities.

On February 7, 2024 OWCP received a December 15, 2023 report by Dr. Xeller, who diagnosed recurrent right wrist CTS and triggering of the ring and pinky fingers. Dr. Xeller recommended repeat surgery to address tingling, numbness, and dexterity problems with the right hand and trigger releases for the ring and pinky fingers. He agreed with Dr. Masson's recommendation for an updated EMG/NCV of the right upper extremity. Dr. Xeller opined that that appellant "had MMI long ago [from surgery(s) 2004-2005]. Now with recurrent condition and triggers of IV, V digits right hand. Needs up to date EMG/NCV to rate. However, in my opinion due to appellant's significant complaints, repeat CTR surgery (now open) and trigger releases IV, V are indicated." Dr. Xeller noted that he was "perplexed by the very high rating given in the past" and indicated that if appellant "were to be rated today," the "highest possible rating" under sixth edition of the A.M.A., *Guides* using Table 15-23, page 449, and Table 15-2 (Digit Regional Grid), page 392, would be 5 percent for right CTS and 8 percent digital impairment for a combined impairment of 11 percent of the right upper extremity. In a supplemental report, Dr. Xeller noted that the December 2023 EMG/NCV study showed recurrent right carpal tunnel syndrome, and recommended repeat surgery and a trigger finger release. He advised that the correct value for an impairment rating was 10 percent rather than 11 percent of the right upper extremity but that he "would hold this rating and he should have surgery."

On February 14, 2024 OWCP found a conflict in medical opinion between Dr. Ellis, in his May 11, 2023 report, and Dr. Xeller, in his December 15, 2023 report, regarding the extent of permanent impairment of appellant's right upper extremity.

On March 15, 2024 OWCP referred appellant, a copy of the medical record, an October 19, 2023 SOAF, and a series of questions to Dr. Stephen Ringel, a Board-certified orthopedic surgeon, for an impartial medical examination.

In a May 7, 2024 report, Dr. Ringel, the impartial medical examiner (IME), noted the accepted diagnoses according to the SOAF included right wrist contusion and right CTS. He also diagnosed bilateral peripheral neuropathy and bilateral flexor tenosynovitis of the index, right, and middle fingers, which he opined were unrelated to the accepted employment incident. Dr. Ringel determined that "the MMI date could be approximately 6 weeks after the work-related injury

(contusion of the wrist, which would have been on or about 9/1/2003)." Dr. Ringel applied the sixth edition of the A.M.A., *Guides* and found zero percent permanent impairment of the right upper extremity from the accepted right wrist contusion. Regarding the diagnosis of right CTS, he indicated that if the condition was causally related to the accepted employment incident, then "the rating by Dr. Xeller of 10 percent would be appropriate."

By decision dated July 16, 2024, OWCP granted appellant a schedule award for an additional 8 percent permanent impairment of the right upper extremity (for a total of 10 percent). OWCP listed the date of MMI as December 15, 2023, the date of Dr. Xeller's examination. The period of the award ran for 24.96 weeks from December 15, 2023 through June 6, 2024.

LEGAL PRECEDENT

The schedule award provisions of FECA[3] and its implementing regulations[4] 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. OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants. As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[5]

It is the claimant's burden of proof to establish permanent impairment of a scheduled member or function of the body as a result of an employment injury.[6] OWCP procedures provide that, to support a schedule award, the file must contain competent medical evidence which shows that the impairment has reached a permanent and fixed state and indicates the date on which this occurred (date of MMI), describes the impairment in sufficient detail so that it can be visualized on review, and computes the percentage of impairment in accordance with the A.M.A., *Guides*.[7] Permanent impairment is to be rated according to the A.M.A., *Guides*, and only after the status of MMI is determined. Before a schedule award can be awarded, it must be medically determined that no further improvement can be anticipated and the impairment must reach a fixed and permanent state, which is known as MMI. MMI means that the physical condition of the injured member of the body has stabilized and will not improve further.[8] The date of MMI is usually considered to be the date of the medical examination that determined the extent of the impairment.[9]

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

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

[6] *See T.H.*, Docket No. 19-1066 (issued January 29, 2020); *D.F.*, Docket No. 18-1337 (issued February 11, 2019); *Tammy L. Meehan*, 53 ECAB 229 (2001).

[7] *Supra* note 5 at Chapter 2.808.5 (March 2017).

[8] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3a(1) (January 2010); *see also J.D.*, Docket No. 19-0032 (issued June 10, 2021); *C.R.*, Docket No. 17-1872 (issued March 8, 2018); *P.L.*, Docket No. 13-1340 (issued October 28, 2013).

[9] *Supra* note 5 at Chapter 3.700.3 (January 2010).

In addressing 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.[10] After a CDX is determined (including identification of a default grade value), the impairment class is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12]

Regarding the application of ROM or DBI 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)."[13]

The FECA Bulletin further advises:

> "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."[14]

Impairment due to CTS is evaluated under the scheme found in Table 15-23, Entrapment/Compression Neuropathy Impairment, and the accompanying relevant text.[15] In Table 15-23, grade modifiers levels (ranging from 0 to 4) are described for the category's clinical studies, functional history, and physical examination 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 is modified up or down based on the Functional Scale section of Table 15-23, using a *Quick*DASH score as an assessment of impact on daily living activities.[16]

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

[10] *M.D.*, Docket No. 20-0007 (issued May 13, 2020); *T.T.*, Docket No. 18-1622 (issued May 14, 2019).

[11] A.M.A., *Guides* 383-492; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[12] *Id.* at 405-12. Table 15-4 and Table 15-5 also provide that, if motion loss is present for a claimant with certain diagnosed elbow and shoulder conditions, permanent impairment may alternatively be assessed using Section 15.7 (ROM impairment). Such a ROM rating stands alone and is not combined with a DBI rating. *Id.* at 398-05, 475-78.

[13] FECA Bulletin No. 17-06 (issued May 8, 2017); *V.L.*, Docket No. 18-0760 (issued November 13, 2018).

[14] *Id.*

[15] 20 C.F.R. § 10.404.

[16] *Id.* at § 10.404(a); *see R.M.*, Docket No. 20-1278 (issued May 4, 2022); *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

percentage of impairment in accordance with the A.M.A., *Guides*, with an OWCP medical adviser providing rationale for the percentage of impairment specified.[17]

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.[18] 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. In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an IME 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.[19]

ANALYSIS

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

The Board finds that OWCP improperly determined that there was a conflict in medical opinion between Dr. Ellis, an attending physician, and Dr. Xeller, OWCP's referral physician, on the issue of increased permanent impairment of appellant's right upper extremity.

Dr. Ellis, in his May 11, 2023 report, provided a rating of 34 percent right upper extremity impairment for "the peripheral nerve injury" and 61 percent impairment of the right upper extremity for range of motion deficits in the hand, including the thumb, middle, and index fingers, and wrist. He then combined these ratings for a total impairment of 74 percent permanent impairment of the right upper extremity. In his December 15, 2023 report, Dr. Xeller diagnosed recurrent right wrist CTS and triggering of the ring and pinky fingers, opined that appellant should undergo further surgery to the right wrist and right and pinky fingers, and indicated that an updated EMG/NCV study was needed in order to rate his permanent impairment. He explained that appellant "had MMI long ago [from surgery(s) 2004-2005]" and that if appellant "were to be rated today," the "highest possible rating" under the sixth edition of the A.M.A., *Guides* would be 11 percent of the right upper extremity, which included 8 percent digit impairment for the triggering of the ring and pinky fingers. In a supplemental report, Dr. Xeller noted that the impairment was 10 percent instead of 11 percent but opined that the rating should be held pending surgery, which he found necessitated by his review of the December 2023 EMG/NCV study showing recurrent right carpal tunnel syndrome.

[17] *Supra* note 5 at Chapter 2.808.6f (March 2017). *See also P.W.*, Docket No. 19-1493 (issued August 12, 2020); *Frantz Ghassan*, 57 ECAB 349 (2006).

[18] 5 U.S.C. § 8123(a). *See R.C.*, Docket No. 18-0463 (issued February 7, 2020); *see also G.B.*, Docket No. 16-0996 (issued September 14, 2016).

[19] 20 C.F.R. § 10.321. *See also J.H.*, Docket No. 22-0981 (issued October 30, 2023); *N.D.*, Docket No. 21-1134 (issued July 13, 2022); *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001); *James P. Roberts*, 31 ECAB 1010 (1980).

As noted above, for a conflict to arise the opposing physicians' viewpoints must be of virtually equal weight and rationale.[20] The Board finds that Dr. Xeller's report supports that appellant had not reached MMI in light of his comments that he required further surgery. As discussed, before a schedule award can be made, it must be medically determined that no further improvement can be anticipated and the impairment must reach a fixed and permanent state, which is known as MMI.[21] The question of when MMI has been reached is a factual one that depends upon the medical findings in the record.[22] Therefore, the Board finds that Dr. Xeller's opinion is insufficient to create a conflict as he recommended against a permanent impairment rating based on his finding that appellant had not reached MMI. As no true conflict existed in the medical evidence at the time of the referral to Dr. Ringel, the Board finds that Dr. Ringel's report may not be afforded the special weight of an IME and should be considered for its own intrinsic value.[23] Dr. Ringel's report is instead considered to be that of a second opinion.[24]

In his May 7, 2024 report, Dr. Ringel reviewed an October 19, 2023 SOAF and the medical record and discussed his physical examination findings. He opined that appellant's "current symptoms and the symptoms dating back to 2003 were unrelated to trauma, but in all medical probability related to peripheral neuropathy and diabetes." Dr. Ringel advised that he had reached MMI approximately six weeks after the injury. Dr. Ringel indicated that if the diagnosis of right-sided CTS was causally related to the accepted employment incident, then "the rating by Dr. Xeller of 10 percent would be appropriate." He did not, however, provide any independent calculations or medical rationale for his impairment rating and failed to make any specific references to the A.M.A., *Guides*.[25] Dr. Ringel's report, therefore, required clarification. No further action was taken by OWCP to obtain a supplemental report prior to issuing the July 16, 2024 schedule award decision. For the foregoing reasons, Dr. Ringel's opinion is of diminished probative value.

It is well established that proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares the responsibility in the development of the evidence to see that

[20] *A.P.*, Docket No. 22-1054 (issued January 6, 2023); *H.B.*, Docket No. 19-0926 (issued September 10, 2020); *C.H.*, Docket No. 18-1065 (issued November 29, 2018); *Darlene R. Kennedy*, *id*.

[21] *C.R.*, Docket No. 19-0523 (issued January 7, 2020); *supra* note 5 at Chapter 3.700.3.a (January 2010).

[22] *N.T.*, Docket No. 21-0236 (issued January 24, 2023); *C.H.*, Docket No. 19-1639 (issued April 3, 2020); *Peter C. Belkind*, 56 ECAB 580 (2005); *Marie J. Born*, 27 ECAB 623 (1976).

[23] *Id*.

[24] *P.L.*, Docket No. 21-0821 (issued April 15, 2022); *L.G.*, Docket No. 20-0611 (issued February 16, 2021). *See also M.G.*, Docket No. 19-1627 (issued April 17, 2020); *S.M.*, Docket No. 19-0397 (issued August 7, 2019) (at the time of the referral for an impartial medical examination there was no conflict in medical opinion evidence; therefore, the referral was for a second opinion examination); *see also Cleopatra McDougal-Saddler*, 47 ECAB 480 (1996) (as there was no conflict in medical opinion evidence, the report of the physician designated as the IME was not afforded the special weight of the evidence, but instead considered for its own intrinsic value as he was a second opinion specialist).

[25] *See R.W.*, Docket No. 24-0746 (issued September 30, 2024); *D.O.*, Docket No. 19-1729 (issued November 3, 2020); *F.B.*, Docket No. 18-0903 (issued December 7, 2018).

justice is done.[26] Once it undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[27]

On remand OWCP shall refer appellant along with the medical record and an updated SOAF to a new physician in the appropriate field of medicine, for an evaluation and second opinion which explains whether appellant has reached MMI and the extent of any increased permanent impairment of a the right upper extremity, warranting a schedule award.[28] 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.

ORDER

IT IS HEREBY ORDERED THAT the July 16, 2024 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded to OWCP for further proceedings consistent with this decision of the Board.

Issued: October 28, 2024
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board

[26] *S.S.*, Docket No. 18-0397 (issued January 15, 2019); *D.G.*, Docket No. 15-0702 (issued August 27, 2015); *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

[27] *S.S., id.*; *Richard F. Williams*, 55 ECAB 343, 346 (2004).

[28] *See E.L.*, Docket No. 23-0515 (issued May 8, 2024).