United States Department of Labor
Employees' Compensation Appeals Board

L.Y., Appellant	)	
and	)	**Docket No. 20-0398**
	)	**Issued: February 9, 2021**
U.S. POSTAL SERVICE, CAPITAL METRO AREA OFFICE, Gaithersburg, MD, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On December 11, 2019 appellant filed a timely appeal from a November 5, 2019 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[2]

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that, following the November 5, 2019 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.*

ISSUE

The issue is whether appellant has met her burden of proof to establish more than 14 percent permanent impairment of her left upper extremity and more than 3 percent permanent impairment of her right upper extremity, for which she previously received schedule award compensation.

FACTUAL HISTORY

This case had previously been before the Board.[3] The facts and circumstances as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On October 27, 2010 appellant, then a 58-year-old retired human resources manager, filed an occupational disease claim (Form CA-2) alleging that she developed bilateral carpal tunnel syndrome while performing repetitive duties which were required by factors of her federal employment.[4] OWCP accepted her claim for bilateral carpal tunnel syndrome, left rotator cuff sprain, and other affections of the left shoulder region not elsewhere classified. Appellant underwent a left carpal tunnel release on February 21, 2011 and a right carpal tunnel release on June 27, 2011. OWCP subsequently expanded acceptance of the claim to include an acquired trigger finger on the right. On October 11, 2012 appellant underwent an arthroscopic left rotator cuff tendon repair with debridement and subacromial decompression. On February 26, 2013 she underwent a right index trigger finger release. OWCP paid appellant wage-loss compensation and she returned to work after each surgery.

By decision dated December 29, 2011, OWCP granted appellant a schedule award for three percent permanent impairment of each upper extremity due to carpal tunnel syndrome.

On August 7, 2013 appellant filed a claim for an additional schedule award (Form CA-7). On February 25, 2014 OWCP granted her a schedule award for an additional four percent permanent impairment of the left upper extremity due to a full-thickness tear of the rotator cuff, for a total of seven percent left upper extremity permanent impairment.[5]

On February 2, 2015 appellant requested reconsideration. She argued that she had an increased total left upper extremity impairment as Dr. Webber's seven percent impairment rating

[3] Docket No. 15-1344 (issued March 10, 2016).

[4] Appellant had retired on July 30, 2010.

[5] This award was based a July 3, 2013 report by Dr. Stephen D. Webber, a Board-certified orthopedic surgeon, who reported seven percent permanent impairment of appellant's left upper extremity based on a full-thickness tear of the rotator cuff.

related only to her shoulder and did not include her carpal tunnel condition. Additional reports from Dr. Webber were submitted.[6]

By decision dated March 10, 2015, OWCP denied appellant's request for reconsideration. Appellant appealed to the Board. By decision dated March 10, 2016, the Board set aside OWCP's March 10, 2015 decision and remanded the case for a *de novo* review.[7]

Following further development, by decision dated November 17, 2016, OWCP found that appellant had an additional 3 percent permanent impairment of the left upper extremity, for a total 10 percent impairment of the left upper extremity. It accorded the weight of the medical evidence to the November 10, 2016 report of Dr. Morley Slutsky, a Board-certified occupational medicine physician serving as OWCP's district medical adviser (DMA), who reviewed July 5 and September 16, 2016 reports of Dr. D. Burke Haskins, a Board-certified orthopedic surgeon and second opinion physician.

In a May 14, 2017 report, Dr. Robert W. Macht, a general surgeon, opined that appellant had reached maximum medical improvement (MMI) by April 30, 2017. He noted appellant's physical examination findings, which included decreased sensation to light touch about all the fingers, slight pain with motion of the right index finger, and no triggering. Dr. Macht also provided active range of motion (ROM) findings, which he noted that were repeated at least three times.[8] Based on diagnosis-based impairment (DBI) methodology, Dr. Macht opined that appellant had 12 percent left upper extremity impairment of the left shoulder and 5 percent left upper extremity impairment for carpal tunnel syndrome, for a total combined left upper extremity permanent impairment of 16 percent. He also opined that she had six percent right upper extremity permanent impairment due to carpal tunnel syndrome and triggering finger. Dr. Macht found under Table 15-2, page 392, of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[9] that appellant had a class 1 or six percent impairment of the right index finger due to continuing triggering, which converted to one percent impairment of the right upper extremity. He also cited to other appropriate sections and tables in the A.M.A., *Guides*. A copy of an April 16, 2014 upper extremity electromyogram and nerve conduction velocity (EMG/NCV) study revealed moderate bilateral median mononueropathy carpal tunnel syndrome, worse on right side, was also submitted.[10] In a

[6] In an October 1, 2014 report, Dr. Webber confirmed that his seven percent rating for the shoulder did not take into account any other impairment of the left upper extremity. In a February 24, 2015 report, he assigned 3 percent for right carpal tunnel syndrome and 7 percent impairment for a right-sided full-thickness rotator cuff tear, for a total right upper extremity impairment of 14 percent.

[7] *See supra* note 3.

[8] This was reported as flexion of 100 degrees, extension of 30 degrees, abduction of 90 degrees, adduction of 30 degrees, internal rotation of 30 degrees and external rotation of 50 degrees.

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

[10] In his initial review of Dr. Macht's May 14, 2017 report, the DMA indicated that the EMG performed on June 2011 was not available for his review. He also noted, while the April 16, 2014 EMG/NCV test was of record, it did not meet the A.M.A., *Guides* criteria for use under Table 15-23 as the electrodiagnostic measurements were unreadable on OWCP's scanned copies.

supplemental report dated October 16, 2017, Dr. Macht related that on May 10, 2017 he had taken three measurements of appellant's left shoulder ROM. He provided the measurements and noted that he had not averaged the measurements, but had utilized the best measurement.

In a report dated December 16, 2017, Dr. Slutsky, the DMA, reviewed Dr. Macht's May 14, 2017 report. He related that appellant's final combined left upper extremity permanent impairment was 13 percent, which was comprised of 12 percent impairment of the left shoulder, the same rating as Dr. Macht, but only 1 percent impairment due to her left carpal tunnel syndrome, for which Dr. Macht had assigned 5 percent. The DMA also related that she had a total combined right upper extremity permanent impairment of three percent, which was composed of two percent for carpal tunnel syndrome, while Dr. Macht had assigned five percent, and one percent for trigger finger, the same percentage assigned by Dr. Macht. He explained that appellant's 12 percent left shoulder permanent impairment rating was based upon ROM methodology, as it exceeded the 6 percent impairment rating found use the DBI methodology. The DMA also related that her left carpal tunnel impairment was rated under the DBI method for nonspecific wrist pain as her left median nerve measurements did not meet the criteria for measurement under Table 15-23, page 449 of the A.M.A., *Guides* for entrapment compression neuropathy. Regarding the right upper extremity, the DMA reported that appellant had a two percent permanent impairment due to carpal tunnel syndrome, for entrapment compression neuropathy, and a 1 percent permanent impairment due to trigger finger, which he noted was the same as Dr. Macht's rating. Regarding her right trigger finger, he explained that no trigger was found during Dr. Macht's examination however she still had some residuals which were consistent with a sprain, therefore, instead of rating based on loss of ROM, her right index finger impairment was rated under the DBI methodology as a right index finger sprain. The DMA concluded that his final assessment of six percent permanent impairment of the right index finger converted to a one percent permanent impairment of the right upper extremity. He totaled appellant's two permanent impairment ratings due to right carpal tunnel syndrome, with her one percent permanent impairment due to trigger finger, to find a combined rating of three percent permanent impairment of the right upper extremity.

By decision dated January 18, 2018, OWCP granted appellant a schedule award for an additional 3 percent permanent impairment of the left upper extremity, for a total 13 percent left upper extremity impairment. No additional impairment was awarded for the right upper extremity greater than the three percent impairment previously awarded. OWCP accorded the weight of the medical evidence to the DMA's December 16, 2017 report, which reviewed Dr. Macht's May 14 and October 16, 2017 reports.

On January 22, 2018 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. During the hearing, held on June 8, 2018, she advised that she was appealing the schedule award decision regarding permanent impairment of her right upper extremity. In support thereof, appellant submitted a duplicate copy of Dr. Macht's May 14, 2017 report.

By decision dated August 6, 2018, the hearing representative vacated OWCP's January 18, 2018 decision. He remanded the case to OWCP for further review by the DMA followed by a *de novo* decision.

In a September 30, 2018 report, the DMA indicated that appellant's final combined left upper extremity permanent impairment was 14 percent. He concurred with Dr. Macht's May 14, 2017 findings that she had 12 percent left shoulder upper extremity impairment, but based this finding on ROM methodology as it yielded the higher impairment over that of the DBI methodology for full-thickness rotator cuff tear with residual dysfunction. The DMA however, indicated that the left carpal tunnel impairment was two percent, not five percent as assigned by Dr. Macht. He further found that the final combined right upper extremity impairment was three percent, which was comprised of two percent impairment for carpal tunnel syndrome and one percent impairment for trigger finger. The DMA opined that appellant was not entitled to an additional schedule award. He concurred with Dr. Macht's one percent right upper extremity impairment for trigger finger. For the right carpal tunnel syndrome, the DMA utilized Table 15-23, page 449, of the A.M.A., *Guides*, and found, like Dr. Macht, a grade modifier for clinical studies of 1 (GMCS) for EMG/NCV testing. However, he found that appellant's condition had a grade modifier for functional history (GMFH) of 1 and a grade modifier for physical examination (GMPE) of 1. The DMA further found that the *Quick*DASH score was invalid. This resulted in an average grade modifier of 1, which resulted in final two percent right upper extremity impairment. The DMA cited to appropriate tables within the A.M.A., *Guides* and provided his calculations. He related that the date of MMI was May 14, 2017, the date of Dr. Macht's impairment evaluation.

OWCP determined that a conflict in medical opinion existed between Dr. Macht and the DMA, Dr. Slutsky, regarding the extent of appellant's left and right upper extremity permanent impairment. It referred appellant, along with a November 1, 2018 statement of accepted facts, to Dr. Sankara Kothakota, a Board-certified orthopedic surgeon, for an impartial medical examination.

In a report dated December 6, 2018, Dr. Kothakota opined that regarding appellant's carpal tunnel syndrome "both sides' problems have been resolved" however he also noted that she had more residual problems on the right side. In the absence of significant objective findings, he found a GMPE of 1. Dr. Kothakota noted that there was no significant grip strength loss and there was no atrophy on examination. He agreed with the DMA's two percent impairment rating for the carpal tunnel diagnoses, noting that he reviewed the DMA's entire report and that his enumeration was accurate. For the left shoulder, Dr. Kothakota indicated that there was no impact or actual injury to the shoulder other than lifting paperwork. He advised that all the degenerative changes seen on the diagnostic testing of the shoulder were related to appellant's age, not to the employment injury. As a result, Dr. Kothakota opined that DBI methodology better represented her impairment than ROM methodology, as the lack of ROM in the left shoulder was most probably related to the arthritic process, a preexisting clinical condition. He opined that as the arthritic process in the shoulder would not be caused by paperwork or lifting boxes, he did not agree with Dr. Macht's impairment findings. Rather, Dr. Kothakota indicated that because part of the left shoulder problems were not related to the employment-related injury, he agreed with the DMA's opinion that the DBI methodology was the best representation of appellant's impairment as ROM impairments would be inaccurate in this patient. The DMA, however, had utilized the ROM methodology, finding that it represented the highest impairment rating. Dr. Kothakota also indicated that he concurred with ratings and numbers provided by the DMA on September 30, 2018.

In a March 7, 2019 letter, appellant indicated that her disagreement with Dr. Kothakota's opinion. She also indicated that the DMA had found that she had 14 percent permanent impairment of her left upper extremity, but she had not been paid the additional 1 percent owed over the 13 percent permanent impairment previously paid.

By *de novo* decision dated March 25, 2019, OWCP denied appellant's claim for an increased schedule award. It accorded the special weight of the medical evidence to Dr. Kothakota's impartial medical opinion.

In a revised *de novo* decision dated April 9, 2019, OWCP notified appellant that the claim for an increased schedule award for the right upper extremity in excess of the three percent impairment previously awarded remained denied. However, an additional one percent impairment to the left upper extremity was awarded, for a total of 14 percent permanent impairment to the left upper extremity. The claims examiner noted that appellant never received the additional one percent left upper extremity impairment which the DMA found that she was entitled to in his September 30, 2018 report and with which Dr. Kothakota agreed.

By separate decision dated April 9, 2019, OWCP awarded appellant an additional one percent schedule award for permanent impairment of the left upper extremity, for a total of 14 percent left upper extremity permanent impairment. The period of the award, equivalent to 3.12 weeks of compensation, ran for the period from July 19 to August 9, 2017.

On April 24, 2019 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. During the hearing, held on August 21, 2019, appellant testified that her physicians had informed her that her preexisting arthritis was exacerbated and permanently aggravated by the employment injury. OWCP subsequently received a July 27, 2019 statement from appellant.

By decision dated November 5, 2019 the hearing representative affirmed OWCP's April 9, 2019 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA,[11] and its implementing federal regulations,[12] 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 loss of a member shall be determined. The method used in making such a determination is a matter which rests in the 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. OWCP evaluates the degree of permanent impairment according to the standards set forth in the

[11] 5 U.S.C. § 8107.

[12] 20 C.F.R. § 10.404.

specified edition of the A.M.A., *Guides*, published in 2009.[13] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[14]

The sixth edition of the A.M.A., *Guides* provides a DBI method of evaluation utilizing the World Health Organization's International Classification of Functioning Disability and Health (ICF).[15] Under the sixth edition, the evaluator identifies the impairment class of diagnosis (CDX), which is then adjusted by a grade modifier for functional history (GMFH), grade modifier for physical examination (GMPE), and grade modifier for clinical studies (GMCS).[16] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[17] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[18]

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

> "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.)[19]

Section 8123(a) 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

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[13] For decisions issued after May 1, 2009 the sixth edition of the A.M.A., *Guides* is used. A.M.A., *Guides* (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also* Part 3 -- Medical, *Schedule Awards,* Chapter 3.700, Exhibit 1 (January 2010).

[14] *P.R.,* Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera,* 12 ECAB 348 (1961).

[15] A.M.A., *Guides* (6th ed. 2009) 3, section 1.3, International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[16] *Id.* at 383-492.

[17] *Id*. at 411.

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

[19] FECA Bulletin No. 17-06 (issued May 8, 2017)*; see also W.H.,* Docket No. 19-0102 (issued June 21, 2019).

third physician who shall make an examination.[20] In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical examiner (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.[21]

OWCP's procedures provide that, if a case has been referred to an IME to resolve a conflict regarding permanent impairment, it is unnecessary to route the file to a DMA as long as the IME explains his or her impairment rating and cites to the appropriate tables and the A.M.A., *Guides.* The DMA should not resolve the conflict in medical opinion.[22]

When OWCP obtains an opinion from an IME for the purpose of resolving a conflict in the medical evidence, and the IME's opinion requires clarification or elaboration, OWCP must secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion.[23] If the referral physician fails to respond or does not provide an adequate response, OWCP should refer appellant for a new impartial medical examination.[24]

ANALYSIS

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

OWCP determined that a conflict in medical opinion existed between Dr. Macht, an attending physician, and the DMA, Dr. Slutsky. Dr. Macht found that appellant had 12 percent permanent impairment of her left shoulder based on DBI methodology and 5 percent permanent impairment for carpal tunnel syndrome, for a total combined left upper extremity impairment rating of 16 percent. He also opined that she had six percent right upper extremity impairment due to carpal tunnel syndrome and trigger finger. The DMA found that appellant had final combined left upper extremity impairment of 14 percent. He concurred with Dr. Macht that there was 12 percent left shoulder upper extremity impairment, but found that it was based on ROM methodology, and that her left carpal tunnel syndrome caused two percent permanent impairment. The DMA also found three percent final combined right upper extremity impairment, which was comprised of two percent impairment for carpal tunnel syndrome and one percent impairment for trigger finger. In order to resolve the conflict of medical opinion regarding the impairment to

[20] 5 U.S.C. § 8123(a); *see also* 20 C.F.R. § 10.321.

[21] *K.D.*, Docket No. 19-0281 (issued June 30, 2020); *J.W.*, Docket No. 19-1271 (issued February 14, 2020).

[22] *See supra* note 14 at Chapter 2.808.6(g) (March 2017). *See also J.M.*, Docket No. 18-1387 (issued February 1, 2019).

[23] *W.H.*, Docket No. 16-0806 (issued December 15, 2016); *supra* note 14 at Chapter 2.810.11(e) (September 2010).

[24] *Id.*; *see also R.W.*, Docket No. 18-1457 (issued February 1, 2019).

appellant's upper extremities, OWCP properly referred her to Dr. Kothakota for an impartial medical examination.[25]

In his December 6, 2018 report, Dr. Kothakota reviewed the DMA's September 30, 2018 report and concurred with his impairment ratings. However, he did not provide specific impairment ratings under the tables of the A.M.A., *Guides* for either the left or the right upper extremity. As such, Dr. Kothakota's impairment rating does not conform to the A.M.A., *Guides* and is of diminished probative value.[26]

The Board also notes that Dr. Kothakota opined that the arthritic process in appellant's left shoulder was a preexisting condition which was unrelated to the May 6, 2008 employment injury. Thus, Dr. Kothakota opined that the DBI methodology better represented her left shoulder impairment than ROM methodology as the lack of ROM was most probably related to the arthritic process, a preexisting clinical condition. However, in determining entitlement to a schedule award, preexisting impairment to the scheduled member are included.[27] Further, Table 15-5 of the A.M.A., *Guides* allows an alternative rating for a rotator cuff injury, full-thickness tear with residual loss under the ROM impairment methodology. Dr. Kothakota failed to provide an impairment for appellant's left shoulder based on his ROM findings despite OWCP's instructions. Moreover, he misstated the DMA's report by indicating that he agreed with the DMA that the DBI methodology was the best representation of appellant's left upper extremity impairment. The DMA's report based her left shoulder impairment on ROM methodology. As Dr. Kothakota's report was incomplete and inaccurate, he failed to resolve the conflict in medical opinion with regard to appellant's left upper extremity.

With regard to appellant's right upper extremity, Dr. Kothakota properly relied on the DMA's two percent impairment rating based on carpal tunnel syndrome as that calculation was proper under the A.M.A., *Guides.* However, he failed to provide any explanation for his reliance on the DMA's one percent impairment based on trigger finger. Dr. Kothakota did not offer any specific clinical or physical findings or opinion regarding appellant's right trigger finger condition. In light of these discrepancies, he has not resolved the conflict in medical opinion with regard to impairment of the right upper extremity.

When OWCP obtains an opinion from an IME for the purpose of resolving a conflict in the medical evidence, and the IME's opinion requires clarification or elaboration, OWCP must secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion.[28] Accordingly, the Board finds that OWCP should have referred the case back to Dr. Kothakota, or to a new impartial medical specialist for clarification. Consequently, the case is remanded for further medical development with regard to appellant's entitlement to a greater

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[25] *B.S.*, Docket No. 19-1717 (issued August 11, 2020); *supra* note 16.

[26] *Supra* note 20; *see N.B.*, Docket No. 07-1622 (issued November 26, 2007).

[27] *C.H.*, Docket No. 17-1065 (issued December 14, 2017); *C.K.*, Docket No. 16-1294 (issued January 13, 2017); *P.W.*, Docket No. 16-0684 (issued October 3, 2016); *J.C.*, Docket No. 15-1780 (issued March 17, 2016); *Peter C. Belkind*, 56 ECAB 580 (2005).

[28] *W.H.*, Docket No. 16-0806 (issued December 15, 2016); *supra* note 14 at Chapter 2.810.11(e) (September 2010).

schedule award for permanent impairment of her left and right upper extremities. After this and other such further development as 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 November 5, 2019 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: February 9, 2021
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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