File Number:
HR20-D-H

RECEIVED MAR 2 8 2019

U.S. DEPARTMENT OF LABOR

OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 50
LONDON, KY 40742-8300
Phone: (202) 693-0045

March 22, 2019

Date of Injury:
Employee:

Dear

This is in reference to your workers' compensation claim. Pursuant to your request for a Review of the Written Record, the case file was transferred to the Branch of Hearings and Review.

The review was completed. As a result of such review, it has been determined that the decision issued by the District Office should be vacated and the case remanded to the district office for further action as explained in the enclosed copy of the Hearing Representative's decision.

Your case file has been returned to the Washington, D.C. District Office. You may contact that office by writing to our Central Mail Room at the following address:

US DEPARTMENT OF LABOR
OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 25 WAS
LONDON, KY 40742

Sincerely,

Division of Federal Employees' Compensation

PAUL H FELSER
FELSER LAW FIRM P.C
7393 HODGSON MEMORIAL DRIVE
SUITE 102
SAVANNAH, GA 31406

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodation(s) and/or modification(s), please contact OWCP.

Washington DC, March 25, 2019

U.S. DEPARTMENT OF LABOR
Office of Workers' Compensation Programs

DECISION OF THE HEARING REPRESENTATIVE

In the matter of the claim for compensation under Title 5, U.S. Code 8101 et. seq. of
Claimant; Employed by the
Case No.

Examination of the Written Record was completed in Washington, D.C. Based on this review, the decision of the District Office dated October 1, 2018 is hereby set aside, and the case is remanded for additional actions, for the reasons set forth below:

The issue for determination is whether the evidence is sufficient to establish entitlement to a schedule award.

The claimant is an employee of the where she worked as a She filed an occupational disease claim on alleging that she developed left thumb CMC arthritis, left wrist carpal tunnel syndrome, left wrist strain/sprain and left wrist dorsal ganglion due to her repetitive work activities involving continual grasping of mail. The claim was accepted for the following work-related medical conditions: aggravation of degenerative joint disease of the left thumb and left carpal tunnel syndrome. The claimant stopped work due to the accepted injury and received ongoing wage-loss compensation based on temporary total disability.

The claimant came under the care of Dr. for treatment of the accepted work injury. She underwent approved surgery on consisting of left thumb CMC arthroplasty; trapezium excision, left wrist; left wrist and hand reconstruction of intermetacarpal ligament one and two using abductor policies longus tendon transfer; left carpal tunnel injection; excision of dorsal and volar carpal ganglion cyst, left wrist.

On the claimant underwent an Office-directed second opinion examination with MD, a Board-certified orthopedic surgeon. In her report dated Dr. advised that current X-rays were obtained in the office because the disc the claimant brought was not viewable. Dr. noted a three-view x-ray of the left hand was obtained and showed complete removal of the trapezium with no remaining osteophytes. There was a good space between the scaphoid and the first metacarpal base. The first metacarpal base appeared to have been nicely suspended using the second metacarpal base.

On the claimant underwent electrodiagnostic studies of the left upper extremity.

On March 16, 2018 the claimant filed form CA-7 requesting approval of a schedule award.

Washington DC, March 25, 2019

In support of the schedule award claim, a report entitled "Functional Capacity Evaluation with Permanent Impairment Rating" dated June 23, 2017 was received, signed by MSEP, Certified Disability Examiner and Dr. This report provided a detailed discussion of the history of injury, medical treatment and examination findings. A permanent impairment rating was provided based on the 6th Edition *AMA Guides to the Evaluation of Permanent Impairment.* 2% permanent partial impairment was assigned based on a diagnosis of carpal tunnel syndrome. 30% permanent partial impairment was assigned based on a diagnosis of thumb CMC arthroplasty with trapezium excision. This was converted to 11% permanent partial impairment of the left upper extremity. These impairment ratings were combined to reflect a total 13% permanent partial impairment of the left upper extremity. Detailed impairment calculations were provided with references to tables and pages used to arrive at these figures.

On June 8, 2018, the case file record was referred to the District Medical Advisor (DMA) with a request for review of the medical evidence to determine whether it was sufficient to establish the claimant had reached maximum medical improvement and had sustained permanent partial impairment of a scheduled member due to the accepted work injury based on proper application of the 6th Edition *AMA Guides*. The DMA was asked to specifically assess the impairment evaluation report of June 23, 2017 and explain whether there were any points of disagreement.

In a report dated June 20, 2018, DMA MD provided his assessment of permanent impairment based on the evidence of record. Dr. opined that an impairment rating based upon a diagnosis of carpal tunnel syndrome was inappropriate as the EMG findings were normal. He asserted peripheral nerve impairment could not be rated using the ROM impairment method. He provided his impairment rating for the left upper extremity using a diagnosis of nonspecific wrist pain, class 1, resulting in 0% impairment. Dr. calculated 28% permanent partial impairment of the left thumb based on a diagnosis of left thumb CMC arthroplasty. He explained that an impairment rating based on ROM could not be performed as there were no documented valid upper extremity range of motion measurements for the left thumb. Dr. explained that the records supported a grade modifier 1 instead of grade modifier 3 for clinical studies as there were no imaging studies other than a mention of the radiographic findings in a report by Dr. If the claimant underwent a thorough history and clinical exam with appropriate imaging studies, the impairment rating could change accordingly. Dr. added that he was not certain whether the patient was actually examined by Dr. since there was no documentation of residual numbness or tingling, no documented examination of the abductor pollicis brevis, no sensory examination, no Tinel's sign and no Phalen's test. There was no documented thumb range of motion, no documented palpatory tenderness and no grind test. In addition, the examiner did not appear to recognize that normal electro diagnostic studies yields no ratable impairment for carpal tunnel syndrome based on the *AMA guides*, 6th Edition.

On July 19, 2018, the claimant underwent a second Office-directed second opinion examination with MD. In her report, Dr. provided her examination

findings including normal strength and range of motion; mildly positive provocative signs for left carpal tunnel syndrome; and normal strength. She expressed agreement with the FCE that the claimant's mild left hand weakness was due to arthritis and surgical treatment for this condition. Disability with regard to repetitive tasks was due to mild median neuropathy, which is known to worsen with repetitive tasks and in certain hand and wrist positions. Dr. noted an EMG in found some ulnar neuropathy on the left that did not appear related to the work injury. She explained it was not possible to determine how much of the claimant's subjective complaints of left hand numbness and tingling were related to work-related carpal tunnel and how much was related to non-work-related ulnar neuropathy.

Effective the claimant elected OPM retirement.

In a formal decision dated October 1, 2018, the District Office denied the claim for schedule award with a finding that the opinion of the DMA represented the weight of medical evidence and failed to establish any ratable impairment of the upper extremity due to the accepted work injury. The DMA noted the impairment evaluation report of provided in support of the scheduled award claim was based on incomplete medical findings and it was not clear whether the claimant had been examined by a physician.

The claimant disagreed with this decision and requested an appeal in the form of a Review of the Written Record before the Branch of Hearings and Review.

In a letter dated October 26, 2018, the claimant advised that she was confused by the DMA report that indicated she had 28% impairment due to a diagnosis of left thumb CMC arthroplasty, but later stated that she did not meet the requirements for an impairment rating as it was not certain whether she was examined by Dr. She argued that she had been consistently seen by Dr. who sent her for the FCE/Impairment Rating, reviewed it, and agreed with it as per his signature. She has intermittent numbness and tingling in both hands, diagnosed with bilateral carpal tunnel as confirmed by EMG test on She was not aware she had to resubmit her medical reports that were already in the file to confirm these findings. She was willing to undergo additional examination or x-rays, but felt that the evidence was sufficient to process her schedule award. OWCP had all of her medical records, reports, x-rays, physical therapy, several medical reports from the second opinion physician, Dr. as well as 12 months of ongoing reports from her treating physician, Dr. The claimant advised she had enclosed a CD-ROM with x-rays taken by Dr. in before surgery, as well as a printed copy of x-rays from OWCP Dr. performed on after surgery. These were printed at the time of the visit. The claimant advised she does not have access to her records, as Dr. was hired by OWCP. She assumed Dr. would have sent these or OWCP would have requested a copy directly from her. The claimant noted she also enclosed a copy of the EMG tests of and the FCE/Impairment rating performed on

A Review of the Written Record was undertaken. A letter was released to the employing agency on advising of the appeal and offering the opportunity for the

submission of comments or additional relevant evidence. As of this date, no response has been received from the employing agency.

Based on my careful consideration of the evidence of record, at this time, I find the case is not in posture for a decision on schedule award entitlement. Additional development of the medical evidence is warranted, before a decision on this issue is rendered.

Section 8107 of the FECA provides that, if there is a permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function. Neither the Act nor the regulations specify the manner in which the percentage of impairment for a schedule award shall be determined. For consistent results and to ensure equal justice for all claimants, the Office has adopted the *AMA Guides to the Evaluation of Permanent Impairment* as a standard for evaluating schedule losses and the Board has concurred in such an adoption.[1]

The period covered by a schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of his or her employment injury. Maximum improvement means that the physical condition of the injured member of the body has stabilized and will not improve further. A schedule award is appropriate where the physical condition of an injured member has stabilized despite the possibility of an eventual change in the degree of functional impairment of the member.[2]

FECA Bulletin 09-03 instructs that the 6th Edition *AMA Guides to the Evaluation of Permanent Impairment* will be utilized to determine schedule award entitlement for awards issued on and after May 1, 2009. The 6th Edition has changed its focus to be more "diagnosis based with these diagnoses being evidence-based when possible."[3] Under Chapter 15, *The Upper Extremities*, the *AMA Guides* states: "Most impairment values for the upper extremity are calculated using the diagnosis-based impairments [(DBI)]."[4] Under section 15.2, the *AMA Guides* explain that "Most impairments are based on the DBI, in which an impairment class is determined by the diagnosis and specific criteria; this is then adjusted by 'non-key' factors (grade modifiers) that may include functional history (FH), physical examination (PE) and clinical studies (CS).... Alternative approaches are also provided for basing impairment on peripheral nerve deficits, CRPS, amputation and range of motion.... Range of motion ratings cannot be combined with other approaches, with the exception of amputation. Complex regional pain syndrome ratings cannot be combined with other approaches."[5]

Before the *A.M.A. Guides* may be utilized, a description of the employee's impairment must be obtained from a physician, which is of sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting

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1 45 ECAB 441 (1991.); 45 ECAB 595 (1994.)

2 39 ECAB ___ (1987); 39 ECAB ___ (1988).

3 A.M.A., *Guides*, page 2

4 *Id.* at 385.

5 *Id.*

restrictions and limitations.[6] The file must contain competent medical evidence, which shows that the impairment has reached a permanent and fixed state and indicates the date of maximum medical improvement. The physician must describe the impairment in sufficient detail to visualize the character and degree of disability, and provide a percentage of impairment based on a specific diagnosis. The attending physician should make the evaluation whenever possible. The report of the examination must always include history of clinical presentation, physical findings, functional history, clinical studies or objective tests, analysis of findings, and the appropriate impairment based on the most significant diagnosis, as well as a discussion of how the impairment rating was calculated. After the necessary medical evidence is obtained, the file should be routed to the District Medical Advisor (DMA) for opinion concerning the nature and percentage of impairment, computed in accordance with the *AMA Guides*, Sixth Edition. As a matter of course, the DMA should provide rationale for the percentage of impairment specified.[7]

FECA Bulletin 17-06 instructs that, under Chapter 15 of the *AMA Guides*, 6th Edition, diagnosis-based impairment (DBI) is the primary method of evaluation of the upper limb and the *Guides* instruct that most impairment values for the upper extremity are calculated using the DBI method. Initially in Chapter 15, when defining DBI, range of motion (ROM) is noted to be used primarily as a physical examination adjustment factor and only to determine actual impairment values when a grid permits its use as an option. Diagnoses in the particular regional grids that may alternatively be rated using ROM are followed by an asterisk (*). If it is clear to the evaluator 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. Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify the methodology used by the rating physician (DBI or ROM) and explain whether the applicable tables in Chapter 15 of the *Guides* identify a diagnosis that can alternatively be rated by ROM. If the *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. In such cases, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating.

In this case, the claimant provided an impairment evaluation report signed by a physical therapist and her attending physician, Dr. dated in support of the schedule award claim. The report contained a permanent impairment evaluation performed according to the 6th Edition *AMA Guides* recommending the claimant sustained 2% permanent partial impairment of the left upper extremity due to the accepted, work-related diagnosis of carpal tunnel syndrome and 30% permanent partial impairment based on a diagnosis of thumb CMC arthroplasty with trapezium excision, also an accepted, work-related condition. These impairment ratings were combined to reflect a total 13% permanent partial impairment of the left upper extremity. Detailed impairment calculations were provided with references to tables and pages used to arrive at these figures.

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[6] 42 ECAB ___ (Docket No. issued).

[7] FECA Procedure Manual, Chapter 2-808-6(d) "*Evaluation of Schedule Awards*".

According to proper procedure, the case was referred to the DMA for evaluation of whether the medical evidence established the claimant reached maximum medical improvement and suffered permanent impairment of a scheduled member based on the 6th Edition *AMA Guides*.

The DMA provided a report dated disagreeing with the impairment evaluation of The DMA used the reported findings to arrive at his own assessment of permanent impairment, reflecting 0% permanent impairment of the left upper extremity due to carpal tunnel syndrome and 28% permanent partial impairment of the left thumb due to CMC arthritis surgery. The DMA found the claimant reached maximum medical improvement as of the date of the impairment evaluation on The DMA further argued that the report of provided incomplete examination findings; and the record did not contain x-ray findings to support 30% impairment of the left thumb; however, this could change if additional medical evidence of this nature was received. The DMA also expressed concern over whether a physician actually examined the claimant On

The District Office denied the claim for schedule award based on the medical opinion of the DMA, with a finding that the evidence did not contain medical evidence from a physician sufficient to establish the claimant sustained permanent impairment due to the accepted work injury.

On appeal, the claimant argued that the file contained extensive examination findings by Dr. her attending physician, and Dr. the second opinion physician, documenting the effect of her accepted condition. The claimant noted that Dr. had signed the impairment evaluation of expressing his agreement. Both Dr. and Dr. had performed x-rays of her left hand before and after surgery.

I find that the claimant has submitted sufficient medical evidence to warrant additional development of the evidence to determine whether she is entitled to a schedule award due to permanent impairment related to the accepted work injury. In prior instances, the Board has found that a report by a physical therapist signed by a qualified physician supporting that the claimant has reached maximum medical improvement and has sustained work-related permanent impairment of a scheduled member according to the 6th Edition *AMA Guides* can form the basis for a schedule award claim, necessitating additional medical development of the issue.[8]

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 responsibility in the development of the evidence to see that justice is done.[9] Once OWCP undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[10]

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[8] Docket No. ; Issued:

[9] *See* 55 ECAB ( ).

[10] *See* Docket No. (issued).

The Board has further noted that, pursuant to FECA's procedures, if there is an indication of permanent impairment in the medical evidence of file, the claims examiner should refer the claim for a second opinion evaluation. The claims examiner may also refer the case to the district medical adviser prior to scheduling a second opinion examination to determine if the evidence in the file is sufficient for the district medical adviser to provide an impairment rating.[11]

In this case, the DMA reviewed the impairment evaluation report signed by Dr. and found that the medical evidence of record was sufficient to establish that the claimant had reached maximum medical improvement and had sustained at least 28% permanent impairment of the left thumb due to the work-related injury. Although the DMA expressed concern over lack of sufficient medical findings in the reports of record, the District Office had the responsibility to obtain an opinion from a second opinion physician for evaluation of the claimant's impairment before making a determination on schedule award entitlement.

It is further noted that the claimant was referred to Dr. for a second opinion examination during the same period during which the issue of schedule award entitlement was under development. When the DMA expressed concern in his report of over lack of sufficient medical evidence supporting the permanent impairment evaluation provided by Dr. it is unclear why Dr. was not asked to offer an opinion on the degree of permanent impairment when she examined the claimant on Although Dr. provided her own examination findings and discussion of the impairment evaluation of her report was not referred to the DMA for consideration.

Lastly, the DMA expressed concern over lack of x-ray studies in the record. As noted by the claimant on appeal, in their reports, both Dr. and Dr. referenced x-ray studies that were performed at their request; however, it does not appear the District Office made an attempt to obtain the reports from these x-ray studies or provide them to the DMA for consideration.

On this basis, the denial of the claim for schedule award was premature and improper. The evidence is sufficient to warrant referral of the claimant for a current second opinion examination by a Board-certified specialist that is familiar with the use of the 6th Edition AMA Guides, to assess the degree of permanent impairment of the left hand and/or left upper extremity due to the accepted, work-related injury. Prior to this referral, the District Office should take reasonable steps to obtain copies of the reports from any x-ray studies of the left hand performed by Drs. McDermott and Jones.

The Statement of Accepted Facts (SOAF) and prior medical records should be provided to the second opinion physician for review prior to the exam. The second opinion physician should be instructed to review the SOAF and medical records, perform a current examination, and provide a permanent impairment rating that is consistent with the 6th Edition *AMA Guides*, taking into account the accepted, work-related conditions; and any additional medical conditions that are contributing to permanent impairment of the left upper extremity. When considering the issue of permanent impairment, there is no apportionment

[11] FECA *Procedure Manual* Chapter 2.808.6(d) (February 2013).

under the FECA, and all medical conditions affecting the scheduled member contributing to permanent impairment should be considered for the impairment rating.

The second opinion physician should discuss the impairment evaluation report of and the DMA report of and explain whether or not there is agreement with either report with regard to the assessment of medical findings or permanent impairment according to the 6th Edition *AMA Guides*. If there are points of disagreement, the reasons for this should be explained. The second opinion physician should address whether an impairment rating can be given for the accepted condition of left carpal tunnel syndrome; of if an alternate diagnosis of unspecified pain of the left wrist should be used, as explained by the DMA in his report of

For the accepted left wrist and left thumb injury, the second opinion physician should explain whether impairment of the left hand and/or left upper extremity can be assessed according to the 6th Edition *AMA Guides* alternative range of motion (ROM) method in addition to the diagnosis-based (DBI) method. If so, impairment ratings based on ROM and DBI should be provided. If ROM is used to assess impairment, the *AMA Guides* require three independent measurements and the greatest ROM should be used for the determination of impairment. The method resulting in the higher impairment rating should be accepted.

In each case, the second opinion physician should explain how the 6th Edition *AMA Guides* were utilized to determine the provided permanent impairment ratings, citing tables and pages used, with sufficiently detailed calculations explaining how the impairment rating was determined. If the physician finds that additional information is necessary to render a proper opinion on MMI or permanent impairment, the Office should undertake appropriate steps to obtain such evidence.

Once the new second opinion report is obtained, the District Office should undertake any additional development of the medical evidence such as it finds warranted, and issue a *de novo* decision on the issue of schedule award entitlement.

On this basis, the schedule award decision dated October 1, 2018 is hereby set aside, and the case is remanded to the District Office for actions consistent with this decision.

Issued:
Washington, D.C.

Electronically Signed

Hearing Representative
Branch of Hearings and Review
for
Director, Office of Workers'
Compensation Programs