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.

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

---

[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.*