United States Department of Labor
Employees' Compensation Appeals Board

M.C., Appellant	)	
and	)	**Docket No. 22-1160**
DEPARTMENT OF THE ARMY, RESEARCH, DEVELOPMENT & ENGINEERING COMMAND, Picatinny Arsenal, NJ, Employer	)	**Issued: May 9, 2023**

Appearances:
Thomas R. Uliase, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On August 2, 2022 appellant, through counsel, filed a timely appeal from a March 23, 2022 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has met her burden of proof to establish greater than 28 percent permanent impairment of her left upper extremity, for which she previously received schedule award compensation.

FACTUAL HISTORY

This case has 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 December 23, 2013 appellant, then a 65-year-old program support specialist, filed a traumatic injury claim (Form CA-1) alleging that on December 20, 2013 she fractured her left wrist when she slipped and fell down while in the performance of duty. She stopped work and returned to full-duty work on January 6, 2014. OWCP accepted appellant's claim for minimally displaced distal radius and ulnar styloid fractures. On September 9, 2014 it expanded the acceptance of her claim to include left carpal tunnel syndrome. On September 15, 2014 appellant underwent OWCP-approved carpal tunnel release surgery.

On March 17, 2015 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In a development letter dated March 31, 2015, OWCP requested that appellant submit an impairment evaluation from her treating physician that addressed whether she had obtained maximum medical improvement (MMI) and to provide a permanent impairment rating in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4]

By decision dated July 22, 2015, OWCP denied appellant's schedule award claim, finding that the medical evidence of record was insufficient to establish that she sustained a permanent impairment due to her accepted December 20, 2013 employment injury.

On July 30, 2015 appellant, through counsel, requested a hearing before a representative of OWCP's Branch of Hearings and Review, which was held on November 20, 2015.

Appellant submitted a November 11, 2015 report from Dr. Nicholas P. Diamond, a physiatrist and pain management specialist, who reviewed appellant's history and provided examination findings. Dr. Diamond diagnosed post-traumatic distal radial and styloid fracture of the left wrist, status-post closed reduction of the left wrist fracture, post-traumatic degenerative joint disease of the left wrist, post-traumatic left carpal tunnel syndrome, and status post left carpal tunnel release. With respect to appellant's left carpal tunnel syndrome, he referred to Table 15-23 (Entrapment/Compression Neuropathy Impairment), page 449, of the A.M.A., *Guides,* and

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[3] Docket No. 17-0586 (issued May 2, 2018).

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

determined that appellant had nine percent permanent impairment of the left upper extremity due to entrapment neuropathy of the left median nerve at the wrist. Dr. Diamond also referred to Table 15-32 (Wrist Range of Motion), page 473, and found seven percent permanent impairment due to left wrist range of motion (ROM) deficits. He then referred to Table 15-31 (Finger Range of Motion), page 470, and calculated ROM deficits for the left index, long, ring, and little finger. Dr. Diamond converted the respective digit impairments to a total hand impairment of 32 percent permanent impairment, which he then converted to an upper extremity impairment of 29 percent due to ROM deficits. He concluded that appellant had a total of 40 percent permanent impairment of the left upper extremity.

By decision dated January 20, 2016, OWCP's hearing representative vacated the July 22, 2015 decision, and remanded the case for OWCP to refer Dr. Diamond's November 11, 2015 impairment rating report to a district medical adviser (DMA).

In a February 3, 2016 report, Dr. Morley Slutsky, a Board-certified occupational medicine physician serving as the DMA, disagreed with Dr. Diamond's impairment rating and opined that appellant had 12 percent permanent impairment of the left upper extremity. He noted that Dr. Diamond's impairment rating included both the wrist and fingers, but the fingers were not accepted conditions. Dr. Slutsky utilized the diagnosis-based impairment (DBI) rating method to find that under Table 15-3 (Wrist Regional Grid), page 395, of the A.M.A., *Guides* appellant had three percent permanent impairment of the left upper extremity for the diagnosis of wrist fracture. With respect to appellant's left carpal tunnel syndrome, he referred to Table 15-23 (Entrapment/Compression Neuropathy Impairment), page 449, and calculated that appellant had nine percent permanent impairment of the left upper extremity. Dr. Slutsky concluded that appellant had a total of 12 percent permanent impairment of the left upper extremity. He noted a date of MMI of November 11, 2015.

By decision dated March 1, 2016, OWCP granted appellant a schedule award for 12 percent permanent impairment of the left upper extremity. The award ran for 37.44 weeks from November 11, 2015 through July 30, 2016 and was based on the February 3, 2016 report of Dr. Slutsky, the DMA.

On March 7, 2016 appellant, through counsel, requested a hearing before a representative of OWCP's Branch of Hearings and Review. By decision dated September 16, 2016, OWCP's hearing representative affirmed the March 1, 2016 decision.

Appellant, through counsel, appealed to the Board.

By decision dated May 2, 2018, the Board set aside the September 16, 2016 decision. The Board found that OWCP had inconsistently applied Chapter 15 of the A.M.A., *Guides* regarding the proper use of either the DBI or ROM rating methodology in assessing the extent of permanent impairment. The Board remanded the case for OWCP to issue a *de novo* decision after development of a consistent method for calculating permanent impairment of the upper extremities.

On remand, OWCP referred appellant, along with a statement of accepted facts (SOAF), back to Dr. Slutsky, the DMA, to provide a permanent impairment rating utilizing both the DBI

and ROM rating methods to determine whether appellant was entitled to an additional schedule award.

In a report dated August 7, 2018, Dr. Slutsky noted his disagreement with Dr. Diamond's impairment rating and contended that Dr. Diamond incorrectly assigned impairment rating for the left index, middle, ring, and little fingers. Utilizing the ROM rating method, he noted Dr. Diamond's ROM measurements and referenced Table 15-30 (Thumb Range of Motion*),* page 468, and calculated one percent permanent impairment, which converted to zero percent hand impairment under Table 15-12, page 421. Dr. Slutsky referenced Table 15-31 (Finger Range of Motion)*,* page 470, to find 30 percent permanent impairment each for the index, middle, ring, and little fingers, which converted to 18 percent permanent impairment for the left hand. For ROM deficits in appellant's left wrist, he referenced Table 15-32 (Wrist Range of Motion)*,* page 473, to find that appellant had six percent permanent impairment of the left upper extremity. Regarding appellant's left carpal tunnel syndrome, Dr. Slutsky reported that he agreed with Dr. Diamond's determination that appellant had nine percent permanent impairment pursuant to Table 15-23 (Entrapment/Compression Neuropathy), page 449. He concluded that appellant had a total of 28 percent left upper extremity permanent impairment pursuant to the Combined Values Chart on page 604. Dr. Slutsky noted a date of MMI of November 11, 2015. He explained that since appellant was previously awarded 12 percent permanent impairment of the left upper extremity she was entitled to an additional 16 percent permanent impairment of the left upper extremity.

By decision dated October 30, 2018, OWCP granted appellant a schedule award for an additional 16 percent permanent impairment of the left upper extremity, resulting in a total 28 percent permanent impairment of the left upper extremity. The award ran for 49.92 weeks and from July 31, 2016 through July 15, 2017.

On November 8, 2018 appellant, through counsel, requested a hearing before a representative of OWCP's Branch of Hearings and Review, which was held on March 4, 2019.

In a report dated February 6, 2019, Dr. Diamond noted his disagreement with Dr. Slutsky's August 7, 2018 report. He concluded that his previous rating of 40 percent permanent impairment of the left upper extremity remained unchanged.

By decision dated April 12, 2019, a hearing representative set aside the October 30, 2018 OWCP decision and remanded the case for an impartial medical examination due to a conflict in medical opinion between Dr. Diamond for appellant and Dr. Slutsky for OWCP regarding appellant's left upper extremity permanent impairment pursuant to the ROM rating method.[5]

On October 8, 2021 OWCP referred appellant, along with a SOAF and a series of questions, to Dr. Kevin White, an osteopathic physician Board-certified in orthopedic surgery, for

[5] The hearing representative noted that both doctors agreed as to the impairment rating for appellant's left carpal tunnel syndrome and left wrist fracture.

an impartial medical examination.[6] In his January 31, 2022 report, Dr. White reviewed appellant's history and noted that her claim was accepted for closed fracture of the left distal radius with ulna and left carpal tunnel syndrome, status post decompression. On examination of appellant's left wrist, he observed tenderness to palpation over the ulnar border and decreased sensation. Dr. White provided three ROM measurements for the left wrist at the following: flexion of 15, 20, and 10 degrees; extension of 48, 40, and 40 degrees; radial deviation of 5, 7, and 10 degrees, ulnar deviation of 30, 30, and 32 degrees, supination of 45, 60, and 65 degrees, and pronation of 80, 80, and 80 degrees. He also provided three ROM measurements for the left fingers. Dr. White indicated that appellant had reached MMI.

Utilizing the DBI-rating method, Dr. White referenced Table 15-3 (Wrist Regional Grid), page 395, and indicated that the class of diagnosis (CDX), appellant's wrist fracture, resulted in a Class 1 impairment with a default value of 3. He assigned a grade modifier for physical examination (GMPE) of 1 due to minimal palpatory findings and a grade modifier for functional history (GMFH) of 1 due to complaints of pain symptoms. Dr. White indicated that a grade modifier for clinical studies (GMCS) was not applicable. He applied the net adjustment formula (GMPE - CDX) + (GMFH - CDX) = (1 - 1) + (1 - 1) = 0, which resulted in no adjustment or three percent permanent impairment of the left upper extremity. With respect to appellant's left carpal tunnel syndrome, Dr. White referred to Table 15-23 (Entrapment/Compression Neuropathy), page 449, and assigned a grade modifier of 3 based on a July 29, 2014 electromyography (EMG) and nerve conduction velocity (NCV) study.[7] He assigned a GMCS of 3, a GMPE of 3, and a GMFH of 3. Dr. White noted that the average of the grade modifiers was three, which moved the upper extremity impairment to nine percent permanent impairment of the left upper extremity. He totaled the 3 percent permanent impairment for appellant's left wrist and the 9 percent permanent impairment for appellant's carpal tunnel syndrome to find a total of 12 percent permanent impairment of the left upper extremity.

By decision dated March 23, 2022, OWCP denied appellant's claim for an increased schedule award.

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[6] OWCP initially referred appellant to Dr. George Burak, a Board-certified orthopedic surgeon, for an impartial medical examination, to resolve the conflict in medical evidence. In his June 25, 2019 report, Dr. Burak noted that he concurred with the impairment rating of 28 percent permanent impairment of the left upper extremity. On August 3, 2019 the DMA reviewed Dr. Burak's June 25, 2019 report and opined that Dr. Burak did not provide sufficient detail to support his impairment rating. OWCP subsequently referred appellant to Dr. Arnold Goldman, a Board-certified orthopedic surgeon, for another impartial medical examination. In reports dated December 9, 2019 and December 10, 2020, Dr. Goldman determined that appellant had 28 percent permanent impairment of the left upper extremity. In a February 1, 2021 report, the DMA indicated that Dr. Goldman failed to document how he arrived at the impairment rating for 28 percent permanent impairment of the left upper extremity.

[7] A July 29, 2014 EMG/NCV study demonstrated severe left sensorimotor median neuropathy.

LEGAL PRECEDENT

The schedule award provisions of FECA[8] and its implementing regulations[9] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage of loss of a member shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants and the Board has concurred in such adoption.[10] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, published in 2009, is used to calculate schedule awards.[11]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides,* an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated.[12] With respect to the wrist, reference is made to Table 15-3 (Wrist Regional Grid) beginning on page 395.[13] After the CDX is determined from the Wrist Regional Grid (including identification of a default grade value), the net adjustment formula is applied using GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[14] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[15]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[16] In Table 15-23, grade modifiers levels (ranging from zero to four) are described for the categories of test findings, history, and physical 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 may be modified up or down based on functional scale, an assessment of impact on daily living activities.[17]

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[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

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

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

[12] *K.R.,* Docket No. 20-1675 (issued August 19, 2022); *M.P.,* Docket No. 13-2087 (issued April 8, 2014).

[13] A.M.A., *Guides* 395-97.

[14] *Id.* at 411.

[15] *Id.* at 23-28.

[16] *Id.* at 449.

[17] *Id.* at 448-49.

The A.M.A., *Guides* also provide that the ROM impairment is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other diagnosis-based sections are applicable.[18] If ROM is used as a stand-alone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are measured and added.[19] Adjustments for functional history may be made if the evaluator determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[20]

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

> "As the [A.M.A.] *Guides* caution that, if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s).
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> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify (1) the methodology used by the rating physician (*i.e.,* DBI or ROM) and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. If the [A.M.A.,] *Guides allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used.*" (Emphasis in the original.)[21]
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> The Bulletin further advises:
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> "If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* allows for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE."[22]

Section 8123(a) of FECA provides that if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical examiner (IME)) who shall make an examination.[23] This is called an impartial medical examination and OWCP will

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[18] *Id.* at 461.

[19] *Id.* at 473.

[20] *Id.* at 474.

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

[22] *Id.*

[23] 5 U.S.C. § 8123(a); *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[24] When a 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.[25]

When OWCP obtains an opinion from an IME for the purpose of resolving a conflict in medical evidence and the specialist's opinion requires clarification or elaboration, OWCP must secure a supplemental report from the specialist to correct the defect in the original report.[26] However, when the IME is unable to clarify or elaborate on the original report or if a supplemental report is also vague, speculative or lacking in rationale, OWCP must submit the case record and a detailed statement of accepted facts to a second IME for the purpose of obtaining a rationalized medical opinion on the issue.[27]

ANALYSIS

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

OWCP properly found a conflict in medical opinion between Dr. Diamond, an attending physician, and Dr. Slutsky, the DMA, regarding appellant's permanent impairment of the left upper extremity under the ROM rating method and, accordingly, referred appellant to Dr. White for an impartial medical examination, pursuant to 5 U.S.C. § 8123(a).[28] In his January 31, 2022 report, Dr. White reviewed appellant's history, and noted that her claim was accepted for closed fracture of the left distal radius with ulna and left carpal tunnel syndrome, status post decompression. Utilizing the DBI rating method, he determined that appellant had 3 percent permanent impairment for her left wrist fracture injury, and 9 percent permanent impairment for her left carpal tunnel syndrome, for a total of 12 percent permanent impairment of the left upper extremity. The Board finds, however, that Dr. White did not provide an impairment rating under the tables of the A.M.A., *Guides* for the left upper extremity using the ROM rating methodology in accordance with the A.M.A., *Guides*. Accordingly, Dr. White's opinion does not conform to the A.M.A., *Guides* and is of diminished probative value.[29]

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[24] 20 C.F.R. § 10.321.

[25] *K.D.,* Docket No. 19-0281 (issued June 30, 2020); *J.W.,* Docket No. 19-1271 (issued February 14, 2020); *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

[26] *D.C.,* Docket Nos. 22-0020 & 22-0297 (issued April 24, 2023); *Raymond A. Fondots,* 53 ECAB 637, 641 (2002); *Nancy Lackner (Jack D. Lackner),* 40 ECAB 232 (1988); *Ramon K. Ferrin, Jr.*, 39 ECAB 736 (1988); *James P. Roberts,* 31 ECAB 1010 (1980).

[27] *See D.C., id.*; *Nancy Keenan,* 56 ECAB 687 (2005); *Roger W. Griffith,* 51 ECAB 491 (2000); *Talmadge Miller,* 47 ECAB 673 (1996); *Harold Travis,* 31 ECAB 1071, 1078 (1979).

[28] *L.Y.,* Docket No. 20-0398 (issued February 9, 2021); *B.S.,* Docket No. 19-1717 (issued August 11, 2020); *Darlene R. Kennedy,* 57 ECAB 414 (2006).

[29] *See H.C.,* Docket No. 21-0761 (issued May 5, 2022); *L.Y.,* Docket No. 20-0398 (issued February 9, 2021); *see Paul R. Evans, Jr.,* 44 ECAB 646, 651 (1993).

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 report.[30] Accordingly, the Board finds that OWCP should have referred the case back to Dr. White for a supplemental report for clarification, or to a new IME. Consequently, the case is remanded for further medical development with regard to appellant's entitlement to a greater schedule award for permanent impairment of her left upper extremity. 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 March 23, 2022 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: May 9, 2023
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

James D. McGinley, Alternate Judge
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[30] *Supra* note 26.