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| R.B., Appellant |) | |
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| and |) | Docket No. 13-2040 |
| |) | Issued: February 5, 2014 |
| DEPARTMENT OF THE NAVY, |) | |
| Camp Pendleton, CA, Employer |) | |
| |) | |

Case Submitted on the Record

Before:
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge

On September 6, 2013 appellant filed a timely appeal from an Office of Workers' Compensation Programs' (OWCP) schedule award decision dated July 5, 2013. Pursuant to the Federal Employees' Compensation Act¹ (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

The issue is whether appellant has more than a 10 percent permanent impairment to his right and left upper extremities.

Appellant, a 53-year-old mail carrier, injured his neck and right shoulder on April 9, 1998 while unloading plywood from a flatbed truck. He filed a claim for benefits under case number xxxxxx881, which OWCP accepted for right shoulder sprain, cervical spondylosis and cervical

¹ 5 U.S.C. § 8101 *et seq.*

vertebral fracture. On December 14, 1998 appellant filed a claim for bilateral carpal tunnel syndrome, causally related to employment factors, under case number xxxxxx545. OWCP accepted bilateral carpal tunnel syndrome. Appellant underwent a right carpal tunnel release procedure on April 9, 1999. On August 16, 1999 he underwent left carpal tunnel release surgery.²

Appellant filed a claim for a schedule award under case number xxxxxx545 based on a partial loss of use of his left and right upper extremities due to his accepted bilateral carpal tunnel condition. By decision dated November 13, 2000, OWCP granted him schedule awards for 10 percent permanent impairment of both the left and right upper extremities. The awards were based upon the May 3, 2000 report of Dr. Arthur Harris, a Board-certified orthopedic surgeon, who rated appellant's upper extremity impairment related to his accepted bilateral carpal tunnel syndrome.

On December 6, 2011 appellant underwent cervical discectomy and cervical fusion at C5-6 and C6-7 for the conditions of cervical spondylosis and cervical radiculopathy. The procedure was performed by Dr. Jamieson S. Glenn, Board-certified in orthopedic surgery.

Appellant underwent an electromyogram (EMG) and nerve conduction studies (NCV) on May 7, 2012 that showed bilateral mild median neuropathies at the wrists; carpal tunnel syndrome, without denervation changes, with no evidence of a large fiber polyneuropathy, ulnar neuropathy or C5-T1 radiculopathy in the arms.

In a report dated December 20, 2012, Dr. Glenn stated that appellant had cervical spondylosis and cervical radicular syndrome, which were now resolved. His status was post C5-6, C6-7 anterior cervical discectomy and fusion. Dr. Glenn further stated that appellant was postbilateral carpal tunnel release with residual paresthetic symptoms. He advised that appellant's cervical fusion appeared to be solid and that his overall upper extremity symptoms had significantly improved. Dr. Glenn noted that appellant had ongoing neck discomfort from mild multilevel spondylosis and myofascial discomfort and status post fusion. He recommended continued conservative treatment and advised that appellant did not need to limit his daily activities or work-related requirements.

On March 15, 2013 appellant filed a Form CA-7 claim for an additional schedule award based on a partial loss of use of his left and right upper extremities.

In a report dated April 22, 2013, Dr. Frederick W. Close, Board-certified in orthopedic surgery, stated that appellant had a two percent impairment to his left and right upper extremities based on the accepted bilateral carpal tunnel condition, pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (sixth edition) (A.M.A., *Guides*). He noted the impairment rating under Table 15-23 at page 449 of the A.M.A., *Guides*.³ Under the heading of "Test Findings," Dr. Close found that appellant had a grade modifier of 1 based on the May 7, 2012 positive electrodiagnostic studies. Under the heading of "History," he

² The hospital report for this procedure is not contained in the instant record.

³ A.M.A., *Guides* 449.

found a grade modifier of 1 based on mild intermittent symptoms of intermittent hypesthesia in the fingers and hands. Under the heading of “Physical Findings,” appellant had a grade modifier of 2, for decreased sensation, based on the EMG/NVS testing evidence of mild sensory loss, median nerves at the wrists. Pursuant to the rating process set forth at page 448, the average value for these modifiers, based on adding 1 plus 1 plus 2, divided by 3, equaled 1.33; this rounded off to an average grade of 1, for a mild grade modifier of 1, which yielded an impairment rating for carpal tunnel syndrome of two percent to each upper extremity.

With regard to appellant’s accepted cervical conditions, Dr. Close found that appellant had no ratable impairment. He advised that spinal injuries did not constitute a scheduled member under FECA. Dr. Close noted that Dr. Glenn reported that appellant’s cervical radicular syndrome had resolved. He stated that appellant had no findings sufficient to rate impairment for his accepted cervical condition under the guidelines.

In a report dated June 23, 2013, an OWCP medical adviser agreed with Dr. Close’s rating that appellant had two percent impairment of his left and right upper extremities pursuant to the sixth edition of the A.M.A., *Guides*.

By decision dated July 5, 2013, OWCP denied appellant an additional schedule award for his right and left upper extremities.

LEGAL PRECEDENT

The schedule award provision of FECA⁴ and its implementing regulations⁵ 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. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.⁶ The claimant has the burden of proving that the condition for which a schedule award is sought is causally related to his or her employment.⁷

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization’s International Classification of Functioning, Disability and Health (ICF).⁸ Under the sixth edition, for upper extremity impairments the evaluator

⁴ 5 U.S.C. § 8107.

⁵ 20 C.F.R. § 10.404. Effective May 1, 2009, OWCP began using the A.M.A., *Guides* (6th ed. 2009).

⁶ *Id.*

⁷ *Veronica Williams*, 56 ECAB 367, 370 (2005).

⁸ A.M.A., *Guides*, *supra* note 3 at 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).⁹ The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).¹⁰

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.¹¹ In Table 15-23, grade modifiers levels (ranging from 0 to 4) are described for the categories 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 by one percent based on functional scale, an assessment of impact on daily living activities.¹²

ANALYSIS

On November 13, 2000 appellant was granted schedule awards for 10 percent impairment of both the left and right upper extremities due to his accepted carpal tunnel syndrome. He filed a request for an additional schedule award on March 15, 2013. OWCP denied an additional schedule award based upon the report of Dr. Close, who found that appellant had two percent impairment to each upper extremity due to the accepted carpal tunnel syndrome.

The A.M.A., *Guides* rates diagnosis-based impairment of the upper extremities at Chapter 15, which states at page 387, Section 15.2 that impairments are defined by class and grade. This section provides:

“The impairment class [IC] is determined first, by using the corresponding diagnosis-based regional grid. The grade is then determined using the adjustment grids provided in Section 15.3.

“Once the impairment class has been determined, based on the diagnosis, the grade is initially assigned the default value, ‘C.’ The final impairment grade, within the class, is calculated using the grade modifiers, or nonkey factors, as described in Section 15.3. Grade modifiers include functional history, physical examination and clinical studies. The grade modifiers are used on the Net Adjustment Formula described ... in Section at 15.3d to calculate a net adjustment. The final impairment grade is determined by adjusting the grade up or down the default value C by the calculated net adjustment. The lowest possible grade is A, and adjustments less than minus 2 from the default value C will automatically be considered A; the highest possible grade is E, and adjustments greater than plus 2 will automatically be considered E. The regional grid is then

⁹ *Id.* at 385-419

¹⁰ *Id.* at 411.

¹¹ *Id.* at 449.

¹² *Id.* at 448-50.

consulted again to determine the appropriate impairment value for the selected class and grade. Grade modifiers allow movement within a class but do not allow movement into a different class.

“The regional grid is used for 2 purposes: (1) to determine the most appropriate class for a specific regional diagnosis and (2) to determine the final impairment after appropriate adjustments are made using the grade modifiers.”¹³

The regional grid is used for 2 purposes: (1) to determine the most appropriate class for a specific regional diagnosis; and (2) to determine the final impairment after appropriate adjustments are made using the grade modifiers.¹⁴

With regard to his bilateral carpal tunnel syndrome, Dr. Close advised that appellant had a grade modifier of 1 for test findings, based on the May 7, 2012 positive electrodiagnostic findings; a grade 1 modifier for history for mild intermittent symptoms; and a grade 2 modifier for physical findings, based on decreased sensation. He then properly totaled the modifiers and found an average of 1, which yielded a two percent impairment for carpal tunnel syndrome in each upper extremity. Dr. Close relied on the appropriate sections and tables of the A.M.A., *Guides* pertaining to rating impairment based on carpal tunnel syndrome and sufficiently explained how he arrived at a two percent impairment rating for the right and left upper extremities.

With regard to peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP procedures indicate that *The Guides Newsletter* “Rating Spinal Nerve Extremity Impairment using the sixth edition” (July/August 2009) is to be applied.¹⁵ The Board notes that an impairment rating can be issued based on radiculopathy pursuant to the July/August 2009 edition of *The Guides Newsletter*. Dr. Close noted that on examination there was no basis for an impairment rating based on appellant’s accepted cervical condition. He noted that Dr. Glenn’s December 2011 cervical discectomy and fusion had resolved appellant’s cervical radicular syndrome and the medical evidence did not reflect sufficient findings to meet the standards for rating an impairment for appellant’s cervical condition as set forth in the sixth edition of the A.M.A., *Guides* and the July/August 2009 edition of *The Guides Newsletter*. OWCP properly denied a schedule award for appellant’s cervical condition.¹⁶

The Board finds that appellant has no more than a 10 percent right and left upper extremity impairment, for which he received a schedule award. OWCP’s medical adviser concurred with Dr. Close’s assessment that appellant had a two percent right and left upper

¹³ *Id.* at 387.

¹⁴ *Id.*

¹⁵ See *G.N.*, Docket No. 10-850 (issued November 12, 2010); see also Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *supra* note 13.

¹⁶ The Board notes that a description of appellant’s impairment must be obtained from appellant’s physician, which must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations. See *Peter C. Belkind*, 56 ECAB 580, 585 (2005).

extremity impairment under the A.M.A., *Guides*. There is no other medical evidence of record addressing permanent impairment under the appropriate edition of the A.M.A., *Guides*. OWCP properly found in its July 5, 2013 decision that appellant had no additional permanent impairment of either the right or left upper extremities.

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has more than a 10 percent permanent impairment of the right and left upper extremities, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the July 5, 2013 decision of the Office of Workers' Compensation Programs be affirmed.

Issued: February 5, 2014
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board