

**United States Department of Labor  
Employees' Compensation Appeals Board**

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C.D., Appellant )

and )

**U.S. POSTAL SERVICE, OKLAHOMA )  
PERFORMANCE CLUSTER, )  
Oklahoma City, OK, Employer )**

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**Docket No. 12-249  
Issued: June 12, 2012**

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

*Case Submitted on the Record*

**DECISION AND ORDER**

Before:

COLLEEN DUFFY KIKO, Judge  
MICHAEL E. GROOM, Alternate Judge  
JAMES A. HAYNES, Alternate Judge

**JURISDICTION**

On November 12, 2011 appellant filed a timely appeal from the May 17, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP) granting a schedule award. Pursuant to the Federal Employees' Compensation Act<sup>1</sup> (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

**ISSUE**

The issue is whether appellant met his burden of proof to establish that he has more than a six percent impairment of his left and right arms, for which he received schedule awards.

**FACTUAL HISTORY**

In June 2007, OWCP accepted that appellant, then a 62-year-old letter carrier, sustained bilateral carpal tunnel syndrome, cervical spondylosis without myelopathy and spinal stenosis of

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<sup>1</sup> 5 U.S.C. §§ 8101-8193.

the lumbar region due to his repetitive work duties over time. On October 18, 2007 he underwent cervical spine surgery, including fusion between C3 and C7. On March 23, 2009 appellant underwent left carpal tunnel release surgery. The procedures were authorized by OWCP.

In a February 4, 2010 report, Dr. Harvey Drapkin, an attending osteopath and Board-certified neurologist, noted that appellant denied major weakness in his arms. He indicated that motor examination of the arms revealed a mild restriction of shoulder motion bilaterally but no major weakness. Sensory testing revealed vibratory and light touch sensation to be preserved over all four limbs and deep tendon reflexes were 1-1/2+ and symmetrical in both upper and lower extremities. Dr. Drapkin stated that on the date of examination, February 4, 2010, he performed electromyography (EMG) testing of the dermatomes from C4 to T1 on the left and found no evidence of active denervation such as fibrillations or positive sharp waves. He indicated that the study was normal.

In an August 13, 2010 report, Dr. Michael Hebrard, an attending physical medicine and rehabilitation physician, noted that appellant had undergone cervical surgery from C3 to C7 and had ongoing complaints. Upon examination, appellant had 3+/5 motor strength in elbow flexion and extension bilaterally and 3+/5 grip strength bilaterally. Using the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6<sup>th</sup> ed. 2009), Dr. Hebrard rated appellant under Table 15-20 on page 434 for peripheral nerve root impairment of the upper extremities affecting the brachial plexus, C5 through C8 and T1. He calculated for the left arm a 43 percent impairment due to moderate sensory deficit and a 38 percent impairment due to moderate motor deficit resulting in a 65 percent impairment of the left arm after use of the Combined Values Chart on page 604. With respect to the right arm, Dr. Hebrard determined that appellant had a 23 percent impairment due to sensory deficit and a 38 percent impairment due to motor deficit resulting in a 52 percent impairment of the right arm after using the Combined Values Chart.

In an October 28, 2010 report, Dr. Michael M. Katz, a Board-certified orthopedic surgeon and OWCP's medical adviser, stated that the medical evidence did not appear to support that appellant had a work-related peripheral nerve injury extending from the cervical region into the arms. He recommended that appellant be referred to a second opinion physician for further evaluation of any permanent impairment.

In a March 2, 2011 report, Dr. Michael S. Smith, Board-certified in physical medicine and rehabilitation, served as the second opinion referral physician. He reported appellant's medical history and the findings on physical examination and diagnostic testing. Upon examination, appellant had a general absence of two-point discrimination in both median nerves and that he had a negative Tinel's sign at both elbows and wrists. The results of February 4, 2010 EMG testing showed normal ulnar nerve conduction on the left and normal findings of C4 through T1 on the left. Dr. Smith stated that appellant reached maximum medical improvement by March 23, 2010 and diagnosed several conditions, including bilateral carpal tunnel syndrome status post release on the left with median nerve dysesthesias, cervical spondylosis and spinal stenosis without myelopathy or radiculopathy, status post cervical spine fusion with limited range of motion and persistent pain, and lumbar spinal stenosis and intermittent back pain without myelopathy or radiculopathy. He determined that, under Table 15-23 on page 449 of the

sixth edition of the A.M.A., *Guides*, appellant had EMG test findings consistent with grade modifier 1, history consistent with grade modifier 3 and physical findings consistent with grade modifier 3. Adding these values yielded an average of 2.33 which rounded down to grade modifier 2. Dr. Smith indicated that, when considering that appellant's disabilities of the arm, shoulder and hand (*QuickDASH*) score fell under the severe range, his condition in each arm fell under a six percent impairment under Table 15-23. He noted that the current examination and most recent EMG test findings did not support an ulnar neuropathy. Dr. Smith further found that, with respect to his cervical and lumbar spondylosis, appellant did not have any findings of spinal nerve injury or myelopathy that could be supported by the spinal nerve tables of the A.M.A., *Guides*. He stated, "As a result, unfortunately, no impairment can be provided for the cervical or lumbar spine." Dr. Smith concluded that appellant had a six percent permanent impairment of his left arm and a six percent permanent impairment of his right arm due to neuropathy associated with the median nerves.

In a March 31, 2011 report, Dr. Ronald H. Blum, a Board-certified orthopedic surgeon serving as an OWCP medical adviser, reviewed the medical evidence. He provided an assessment of appellant's arm impairment, under Table 15-23 of the sixth edition of the A.M.A., *Guides*, that was in accordance with the evaluation of Dr. Smith and agreed that appellant had a six percent permanent impairment of his left arm and a six percent permanent impairment of his right arm. Dr. Blum noted that Dr. Smith found no evidence for myelopathy or radiculopathy in the upper and lower extremities resulting from the accepted spinal conditions and posited that, therefore, appellant had no permanent impairment resulting from the accepted spinal conditions.

In a May 17, 2011 decision, OWCP granted appellant schedule awards for a six percent permanent impairment of his left arm and a six percent permanent impairment of his right arm. The awards ran for 37.44 weeks March 22 to December 22, 2010 and were based on the opinions of Dr. Smith and Dr. Blum.

### **LEGAL PRECEDENT**

The schedule award provision of FECA<sup>2</sup> and its implementing regulations<sup>3</sup> 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.<sup>4</sup> The effective date of the sixth edition of the A.M.A., *Guides* is May 1, 2009.<sup>5</sup> It is well established that in determining the amount of a

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<sup>2</sup> *Id.* at § 8107.

<sup>3</sup> 20 C.F.R. § 10.404 (1999).

<sup>4</sup> *Id.*

<sup>5</sup> FECA Bulletin No. 09-03 (issued March 15, 2009).

schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included.<sup>6</sup>

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.<sup>7</sup> In Table 15-23, grade modifier levels (ranging from zero to four) 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.<sup>8</sup>

### ANALYSIS

OWCP accepted that appellant sustained bilateral carpal tunnel syndrome, cervical spondylosis without myelopathy and spinal stenosis of the lumbar region due to his repetitive work duties overtime. On October 18, 2007 appellant underwent cervical spine surgery, including fusion between C3 and C7. On March 23, 2009 he underwent left carpal tunnel release surgery.

OWCP granted appellant a schedule ward for a six percent permanent impairment of both arms. The Board finds that it properly granted appellant this award based on the opinion of Dr. Smith, Board-certified in physical medicine and rehabilitation physician serving as an OWCP referral physician and the opinion of Dr. Blum, a Board-certified orthopedic surgeon serving as an OWCP medical adviser.

In a March 2, 2011 report, Dr. Smith discussed his findings and provided an opinion that appellant had a six percent permanent impairment in his left arm and a six percent permanent impairment in his right arm under the standards of the sixth edition of the A.M.A., *Guides*.<sup>9</sup> He properly applied these standards to reach his conclusion about appellant's permanent arm impairment.

Dr. Smith properly made reference to Table 15-23 (Entrapment/Compression Neuropathy Impairment) on page 449 of the sixth edition of the A.M.A., *Guides*.<sup>10</sup> He chose grade modifiers

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<sup>6</sup> See Dale B. Larson, 41 ECAB 481, 490 (1990); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.b. (June 1993). This portion of OWCP procedure provides that the impairment rating of a given scheduled member should include "any preexisting permanent impairment of the same member or function."

<sup>7</sup> See A.M.A., *Guides* 449, Table 15-23.

<sup>8</sup> A survey completed by a given claimant, known by the name *QuickDASH*, may be used to determine the Function Scale score. *Id.* at 448-49.

<sup>9</sup> On appeal, appellant alleged that, because his claim was accepted in 2007, his impairment should have been evaluated under the fifth edition of the A.M.A., *Guides*. However, OWCP's decision regarding impairment was not issued until after May 1, 2009 and therefore evaluation of appellant's impairment under the sixth edition of the A.M.A., *Guides* was appropriate. See *supra* note 5.

<sup>10</sup> *Supra* note 7.

in each arm from the table for the various categories, including test findings (grade modifier 1), history (grade modifier 3) and physical findings (grade modifier), based on the findings of record. Dr. Smith then correctly averaged the grade modifiers to find that appellant's condition fell under grade modifier 2 and he considered appellant's functional scale (per the *QuickDASH* score) to conclude that he had a six percent impairment in each arm under Table 15-23.<sup>11</sup> The evidence of record did not show that appellant had ulnar neuropathy that warranted an impairment rating. Dr. Smith also properly found that appellant did not have any findings of spinal nerve injury or myelopathy that could be supported with the modified spinal nerve tables of the A.M.A., *Guides*, such that he would have an impairment rating on such a basis. Therefore, he correctly concluded that appellant had a six percent permanent impairment of his left arm and a six percent permanent impairment of his right arm due to neuropathy associated with the median nerves.

Dr. Smith's assessment of appellant's arm impairment was also supported by the opinion of Dr. Blum. In a March 31, 2011 report, Dr. Blum provided an opinion that Dr. Smith's calculation of appellant's arm impairment was correct under the relevant standards of the A.M.A., *Guides*.

The record contains an August 13, 2010 report in which Dr. Hebrard, an attending physical medicine and rehabilitation physician, elected to rate appellant under Table 15-20 on page 434 of the A.M.A., *Guides* for peripheral nerve root impairment of the upper extremities affecting the brachial plexus, C5 through C8 and T1. He concluded that appellant had a 65 percent impairment of the left arm and a 52 percent impairment of the right arm. The Board finds that this opinion on permanent impairment is not supported by the evidence of record as there is no evidence that appellant has peripheral nerve root impairment of the upper extremities affecting the brachial plexus, either in the form of a preexisting injury or a work-related injury. Appellant's claim was accepted for cervical spondylosis without myelopathy and the physical findings and diagnostic testing results do not support that he had a cervical myelopathy or radiculopathy.

The Board notes that there is no medical evidence of record showing that appellant has more than a six percent permanent impairment of his left arm and a six percent permanent impairment of his right arm, for which he already received schedule awards. For these reasons, OWCP properly declined to award appellant schedule award compensation for a greater impairment.

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.

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<sup>11</sup> *Id.* On appeal, appellant alleged that Dr. Smith's evaluation was invalid because he performed a cursory physical examination. The Board finds, however, that Dr. Smith performed a comprehensive physical examination and provided an extensive evaluation of appellant's impairment under the relevant standards.

**CONCLUSION**

The Board finds that appellant did not meet his burden of proof to establish that he has more than a six percent permanent impairment of his left arm and a six percent permanent impairment of his right arm, for which he received schedule awards.

**ORDER**

**IT IS HEREBY ORDERED THAT** the May 17, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 12, 2012  
Washington, DC

Colleen Duffy Kiko, Judge  
Employees' Compensation Appeals Board

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

James A. Haynes, Alternate Judge  
Employees' Compensation Appeals Board