United States Department of Labor
Employees' Compensation Appeals Board

D.U., Appellant	)	
and	)	**Docket No. 13-2086**
	)	**Issued: February 11, 2014**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, St. Louis, MO, Employer	)	

Appearances:
Alan J. Shapiro, Esq. for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 13, 2013 appellant, through his attorney, filed a timely appeal from a July 15, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP) granting him a schedule award. Pursuant to the Federal Employees' Compensation Act[1] (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 has more than a one percent permanent impairment of each arm, for which he received schedule awards.

FACTUAL HISTORY

This case has previously been before the Board. In decisions dated March 15 and December 20, 2006, March 19, 2008 and July 27, 2010, the Board affirmed OWCP's decisions

[1] 5 U.S.C. § 8101 *et seq.*

finding that appellant did not establish bilateral carpal tunnel syndrome causally related to factors of his federal employment.[2] By order dated February 15, 2012, the Board set aside a March 22, 2011 decision that improperly informed appellant of his appeal rights.[3] It remanded the case for an appropriate decision on his request for reconsideration. The facts of the case as set forth in the Board's prior decisions and order are hereby incorporated by reference.

In a decision dated April 10, 2012, OWCP vacated its September 25, 2009 decision and accepted appellant's claim for bilateral carpal tunnel syndrome.

On May 4, 2012 appellant filed a claim for a schedule award. By letter dated July 26, 2012, OWCP referred him to Dr. Charles Mannis, a Board-certified orthopedic surgeon, for a second opinion examination. In a report dated August 13, 2012, Dr. Mannis discussed appellant's history of hand tingling and pain in 2004. He noted that electrodiagnostic testing was normal but that a clinical evaluation showed carpal tunnel syndrome bilaterally, which was confirmed by subsequent bilateral carpal tunnel releases around 2005. On examination, Dr. Mannis found no tenderness and a full range of motion of the wrists and fingers bilaterally without swelling. He further found good pinch strength, grip strength of 3/5 with no thenar eminence atrophy or weakness. Dr. Mannis stated, "Sensory evaluation to pinprick reveals hypoesthesia over the radial and median nerve distribution bilaterally. Ulnar nerve sensation appears to be unremarkable." He diagnosed "status post bilateral carpal tunnel release[s] with mild residual hypoesthesia." Dr. Mannis applied Table 15-23 on page 449 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (6th ed. 2009) (A.M.A., *Guides*), and found that appellant had a two percent permanent impairment of each upper extremity.

On September 4, 2012 Dr. Daniel D. Zimmerman, an OWCP medical adviser, informed Dr. Mannis that it was not appropriate to rate appellant's impairment due to carpal tunnel syndrome using Table 15-23 of the A.M.A., *Guides* as he had normal electrodiagnostic studies. He advised that the impairment could be rated using Section 15.2 of the A.M.A., *Guides* and requested a supplemental opinion.

In a report received October 16, 2012, Dr. Mannis identified a class 1 impairment due to wrist pain using the wrist regional grade set forth in Table 15-3 on page 395 of the A.M.A., *Guides*, which yielded a default value of one percent. He found a grade modifier of two for functional history and physical examination based on residual hypoesthesia at the median nerve, and a grade modifier of zero for clinical studies. Utilizing the net adjustment formula discussed above, (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX) or (2-1) + (2-1) + (0-1) = 1, yielded an adjustment of one, for a one percent impairment of each arm.

[2] Docket No. 06-328 (issued March 15, 2006); Docket No. 06-1999 (issued December 20, 2006); Docket No. 07-2326 (issued March 19, 2008); Docket No. 10-144 (issued July 27, 2010). On May 25, 2005 appellant, then a 42-year-old medical technologist, filed an occupational disease claim alleging that he sustained a repetitive injury to both hands in the course of his federal employment.

[3] *Order Remanding Case*, Docket No. 11-1228 (issued February 15, 2012).

On October 16, 2012 Dr. Zimmerman concurred with the one percent permanent impairment of each upper extremity rated by Dr. Mannis.

In an impairment evaluation dated August 2, 2012, received by OWCP on October 26, 2012, Dr. Neil Allen, a Board-certified internist and neurologist, discussed appellant's complaints of numbness and weakness in the hands bilaterally. On examination of the left wrist, he found mild thenar and hyothenar atrophy, a loss of two-point discrimination, and a loss of sensation at the palmar hand surface. For the right wrist, Dr. Allen found mild thenar atrophy and reduced two-point discrimination over the first digit, and a loss of sensation in the thumb, thenar and digits. He found a negative Phalen's and reverse Phalen's test bilaterally and measured range of motion of both wrists. Dr. Allen concluded that appellant had a 23 percent bilateral wrist impairment due to loss of range of motion of the wrists according to Table 15-32 on page 473. He adjusted the impairment upward based on pain with minimal activity and a *Quick*DASH score of 66, to find a final impairment rating of 25 percent bilaterally.

On November 14, 2012 Dr. Zimmerman noted that Dr. Allen relied upon range of motion in determining the extent of impairment without providing measurements for either passive range of motion or multiple measurements for range of motion as required under Chapter 15. He thus found that the range of motion measurements lacked credibility and advised that the prior right and left upper extremity finding in October 2012 should not be modified.

By decision dated December 27, 2012, OWCP granted appellant a schedule award for a one percent permanent impairment to each upper extremity. The period of the awards ran for 6.24 weeks from August 13 to September 25, 2012.

On January 3, 2013 appellant, through his attorney, requested a telephone hearing before an OWCP hearing representative. At the telephone hearing, held on April 19, 2013, counsel contended that Dr. Allen's August 2, 2012 report established that appellant had more than a one percent impairment of each extremity. Counsel further asserted that the A.M.A., *Guides* allowed the use of range of motion to rate his impairment and that it should be used as it yielded the more favorable result. He indicated that Dr. Allen had prepared an additional report addressing Dr. Mannis' findings.

In a supplemental report dated January 22, 2013, received by OWCP on May 6, 2013, Dr. Allen advised that the diagnosis-based impairment (DBI) grid used by Dr. Mannis to rate appellant's impairment contained an asterisk, which indicated that range of motion could also be used as a stand-alone rating. He asserted, "As [appellant] has suffered a significant range of motion impairment in his wrists, the range of motion method would be the most appropriate mechanism in rating [his] impairment rather than the DBI method as outlined in the [A.M.A., *Guides*]."

In a report dated July 15, 2013, an OWCP hearing representative affirmed the December 27, 2012 decision.

LEGAL PRECEDENT

The schedule award provision of FECA,[4] and its implementing federal regulations,[5] 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[6] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[7]

The sixth edition requires identifying 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).[8] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

The A.M.A., *Guides* at Section 15.4(f) provides:

> "The diagnosis of a focal neuropathy syndrome, "must be documented by sensory and motor nerve conduction studies and/or needle EMG [electromyogram] in order to be rated as impairment, using this section. If nerve conduction testing has not been performed or does not meet this section's diagnostic criteria, there is no ratable impairment from this section. These cases may still be rated in Section 15.2, Diagnosis-Based Impairment, and with the appropriate regional grid, using the diagnosis of nonspecific hand, wrist, or elbow pain, depending on the affected region."[9]

The A.M.A., *Guides* at Section 15.7 provides:

> "Range of motion should be measured after a 'warm up,' in which the individual moves the joint through its maximum range of motion at least [three] times. The range of motion examination is then performed by recording the active measurements from [three] separate range of motion efforts…. All measurements should fall within 10 [degrees] of the mean of these three measurements. The

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id*. at 10.404(a).

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (February 2013); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[8] A.M.A., *Guides* 494-531.

[9] *Id*. at 445.

maximum observed measurement is used to determine the range of motion impairment."[10]

ANALYSIS

OWCP accepted that appellant sustained bilateral carpal tunnel syndrome causally related to factors of his federal employment. On May 4, 2012 appellant filed a claim for a schedule award. On August 13, 2012 Dr. Mannis, an OWCP referral physician, reviewed appellant's history of normal electrodiagnostic testing but positive clinical findings of carpal tunnel syndrome with bilateral carpal tunnel releases in 2005. He measured normal range of motion on examination without atrophy, grip weakness or swelling. Dr. Mannis determined that appellant had hypoesthesia over the radial and median nerve bilaterally. He diagnosed mild residual hypoesthesia following bilateral carpal tunnel releases. Citing Table 15-23 on page 449 of the A.M.A., *Guides*, Dr. Mannis determined that appellant had a two percent permanent impairment of each upper extremity.

On September 4, 2012 Dr. Zimmerman found that the A.M.A., *Guides* did not provide a rating for carpal tunnel syndrome using Table 15-23 with normal electrodiagnostic testing. In a supplemental report dated October 16, 2012, Dr. Mannis determined that appellant had a class 1 impairment due to wrist pain according to the wrist regional grid at Table 15-3 on page 395, which yielded a default impairment value of one percent. He applied grade modifiers of two for functional history and physical examination based on his finding of residual hypoesthesia and a grade modifier of zero for clinical studies, which yielded an adjustment of one, for a one percent permanent impairment of each upper extremity.[11] As appellant had normal electrodiagnostic testing, it was appropriate to rate his impairment using the diagnosis of wrist pain set forth at Section 15.2.[12] On October 16, 2012 Dr. Zimmerman concurred with Dr. Mannis' finding of a one percent upper extremity impairment. The Board finds that Dr. Mannis' report constitutes the weight of the evidence and establishes that appellant has no more than a one percent permanent impairment of each upper extremity.

In an August 2, 2012 impairment evaluation, Dr. Allen found mild thenar and hypothenar atrophy of the wrists, reduced sensation bilaterally and a loss of range of motion. He concluded that appellant had a 23 percent permanent impairment of the bilateral wrists due to reduced motion according to Table 15-32 on page 473 of the A.M.A., *Guides*, which he adjusted upward due to pain and a *Quick*DASH score of 66 to find a 25 percent bilateral wrist impairment. In a supplemental report dated January 22, 2013, Dr. Allen maintained that range of motion could be used as an alternative rating method pursuant to the DBI grid. Dr. Zimmerman reviewed Dr. Allen's report and determined that he did not provide valid range of motion measurements as required by section 15.7a of the A.M.A., *Guides*. He found that Dr. Allen's range-of-motion measurements were not reliable and that OWCP should not alter the rating provided by

[10] *Id*. at 464.

[11] Dr. Mannis used the net adjustment formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), or (2-1) + (2-1) + (0-1) = 1, to find a positive adjustment of one.

[12] *See supra* note 10.

Dr. Mannis. The A.M.A., *Guides* require the rating physician to obtain three measurements per joint motion. The measurements are then averaged and each of the three measurements shown must be within 10 degrees of the calculated average. The maximum observed measurement is then used to determine the range of motion impairment. It does not appear from Dr. Allen's report that the physician obtained three joint measurements. Consequently, his report does not conform to the A.M.A., *Guides* and is of diminished probative value.[13] The Board finds that appellant has a one percent permanent impairment of each upper extremity. There is no probative evidence showing 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.

CONCLUSION

The Board finds that appellant has no more than a one percent permanent impairment of each upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the July 15, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 11, 2014
Washington, DC

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

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

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

[13] *See Mary L. Henninger*, 52 ECAB 408 (2001).