

FACTUAL HISTORY

This is the second appeal before the Board.² On June 19, 2002 appellant, a 51-year-old mail processor, filed a Form CA-2 claim for benefits, alleging that she developed a bilateral de Quervain's tenosynovitis condition in her wrists, causally related to factors of her employment.

In an October 20, 2005 report, Dr. James N. Nutt, Board-certified in orthopedic surgery, stated that appellant's right-sided de Quervain's tenosynovitis was completely resolved with decompressive surgery of the first dorsal compartment. He advised that she had persistent left de Quervain's tenosynovitis which has been ongoing despite the fact that she had been receiving splinting and injection treatment. Dr. Nutt diagnosed bilateral de Quervain's disease, left median epicondylitis and a history of irritation of the ulnar nerve in the left cubital tunnel based on electromyogram (EMG) results. He opined that the right de Quervain's disease had resolved and that appellant's primary problem was the residual left de Quervain's tenosynovitis which was consistent with her history of radial styloid pain, tenderness over the radial styloid and a positive Finkelstein's test. Dr. Nutt asserted that she did not have clinical findings which suggested a clinically active left ulnar nerve dysfunction; he also advised that she had a left median epicondylitis consistent with a tenderness over the condyle and pain on forced wrist elbow flexion with the elbow extended. He stated that the soreness in appellant's first carpal metacarpal joint contributed to the soreness in the radial wrist, especially with use. Appellant related that Dr. Liss had spoken with her about surgery on the left wrist similar to the right-sided procedure; however, she had refused.

Dr. Nutt opined that tenosynovitis was of questionable relationship to work-related activities. He advised that it could be precipitated by trauma and by repetitive motion activities such as drumming, butchering, sewing or to a generalized tendinitis associated with a hyperthyroid disease, rheumatoid arthritis, psoriatic arthritis, pregnancy; appellant showed no clinical manifestations of these conditions. Dr. Nutt further stated that de Quervain's tenosynovitis was often caused by accessory tendons in the first compartment, a finding at the time of her June 2002 surgery. He credited appellant's attribution of her symptoms to her work activities but opined that her current left wrist condition was complicated by the long interval and inactivity since she was gainfully employed, and by the emotional component of refusing to consider a surgery that is relatively simple and safe with an excellent history of efficacy, as demonstrated in her right wrist. Dr. Nutt opined that she should be considered someone who probably had a condition at least partly aggravated by the work she originally did as a precipitating cause.

On April 27, 2006 OWCP accepted the claim for the condition of bilateral radial styloid tenosynovitis, including the June 5, 2020 right wrist surgery. It stated, however, that based on Dr. Nutt's October 20, 2005 report appellant had recovered from the effects of this condition as it related to her right upper extremity. OWCP advised that surgical release on the left side was still medically necessary and also authorized by OWCP.

² Docket No. 12-176 (issued October 12, 2012) discussed *infra* at page 6.

On July 16, 2010 appellant filed a Form CA-7 claim for a schedule award based on a partial loss of use of her left and right upper extremities.

In an April 6, 2010 report, Dr. Nicholas Diamond, an osteopath, found that appellant had a 10 percent impairment of the left upper extremity and a 2 percent right upper extremity impairment pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (sixth edition) (A.M.A., *Guides*). Applying the net adjustment formula at pages 399, 406, 449 and 395 of the A.M.A., *Guides*,³ he found that she had a class 1 impairment, the rating utilized at the elbow regional grid at Table 15-4, page 399 for left medial epicondylitis. Dr. Diamond calculated the functional history grade by using the *QuickDASH* test, a questionnaire which calculates functional disability grade by rating the difficulties a patient experiences in performing basic activities of daily living. He related that appellant had a 63 percent *QuickDASH* score, which yielded a grade modifier of three for functional history, for a severe problem which included pain/symptoms with less than normal activity, pursuant to Table 15-7, page 406; a grade modifier of two for physical examination, for pain/symptoms with less than normal activity, pursuant to Table 15-7, page 406; and a grade modifier of zero for clinical studies.⁴ Pursuant to the formula set forth at Table 15-21, Dr. Diamond then subtracted the grade modifier of one from functional history, physical examination and clinical history, which yielded a net adjusted grade of 2 plus 1 plus negative 1 -- a total net adjustment of 2, for a two percent impairment of the left upper extremity.

Regarding an impairment for left ulnar nerve entrapment at the elbow, Dr. Diamond rated a six percent impairment pursuant to Table 15-23, page 449 of the A.M.A., *Guides*, the table used for calculating entrapment/compression neuropathy impairment.⁵ Using this table, he rated a grade modifier of one for test findings based on conduction delay; a grade modifier of two for physical findings based on decreased sensation; a total of 5, average 2, for an overall five percent upper extremity impairment. Dr. Diamond added an additional 1 percent from the 63 percent *QuickDASH* test for a 6 percent total impairment for left ulnar nerve entrapment at the elbow.

Regarding an impairment for left wrist tenosynovitis, Dr. Diamond rated a two percent impairment pursuant to the wrist regional grid at Table 15-3, page 395 of the A.M.A., *Guides*, the table used for calculating upper extremity impairments based on the wrist.⁶ Using this table, he rated a grade modifier of three for functional history based on the 63 percent *QuickDASH* score; a grade modifier of two for physical examination, pursuant to Table 15-7, page 406; and a grade modifier of zero for clinical studies. Pursuant to the formula set forth at Table 15-21, Dr. Diamond then subtracted the grade modifier of one from functional history, physical examination and clinical history, which yielded a net adjusted grade of 2 plus 1 plus negative 1 -- a total net adjustment of 2, for a two percent impairment of the left upper extremity.

³ A.M.A., *Guides* 399, 406, 449 and 395.

⁴ *Id.* at 406.

⁵ *Id.* at 449.

⁶ *Id.* at 395.

Dr. Diamond also rated a two percent right upper extremity impairment pursuant to the wrist regional grid at Table 15-3. He arrived at this rating by rendering the same findings for the right wrist that he calculated for the two percent impairment of the left wrist, above.

In a July 9, 2010 statement of accepted facts (SOAF), it was indicated that appellant had filed another claim under case file number xxxxxx561 which OWCP accepted for left lateral elbow tendinitis; she first became aware of this condition on March 3, 1998. The SOAF stated that pursuant to this claim she accepted a limited duty offer on April 2, 2002 for the position of mail processor with restrictions. In addition, OWCP accepted a claim for right forearm strain which occurred on September 12, 1998 under case file number xxxxxx640.

In a July 13, 2010 report, Dr. Morley Slutsky, a specialist in occupational medicine and an OWCP medical adviser, found that appellant had a one percent impairment of the left upper extremity for her accepted de Quervain's tenosynovitis condition and a zero percent impairment of her right upper extremity pursuant to the sixth edition of the A.M.A., *Guides*.

By decision dated January 13, 2011, OWCP granted appellant a schedule award for a one percent permanent impairment of the right upper extremity for the period April 6 to 20, 2011, for a total of 3.12 weeks of compensation. By decision dated August 5, 2011, OWCP's hearing representative amended its prior decision and found that appellant had a one percent impairment of his left upper extremity. In all other respects, it affirmed the January 13, 2011 schedule award decision.

In an order dated October 12, 2012, the Board set aside the August 5, 2011 decision. Noting that preexisting impairments to the scheduled member must be included when determining entitlement to a schedule award, it found that the case before the Board, case file number xxxxxx031, should be combined with the two other accepted claims for upper extremity conditions; case file number xxxxxx561, which OWCP accepted for left lateral elbow tendinitis, and case file number xxxxxx640 which was accepted for right arm strain. The Board therefore remanded the case to OWCP to combine the records of all three relevant case numbers and directed it to issue an appropriate schedule award decision following full consideration of all medical evidence pertaining to appellant's accepted upper extremity conditions.

In a February 10, 2013 report, Dr. Arnold T. Berman, a specialist in orthopedic surgery and an OWCP medical adviser, found that appellant had a two percent impairment of the left upper extremity for left lateral epicondylitis and left wrist de Quervain's tenosynovitis condition and a one percent impairment of her right upper extremity for right wrist de Quervain's tenosynovitis condition pursuant to the sixth edition of the A.M.A., *Guides*. With regards to the left wrist, he found that she had a class 1, grade C impairment, the rating utilized at the elbow regional grid at Table 15-4, page 399 the A.M.A., *Guides*,⁷ for left lateral epicondylitis.⁸ Dr. Berman stated that, pursuant to the adjustment grid at Table 15-7, page 406,⁹ appellant had a

⁷ *Id.* at 399.

⁸ Dr. Berman stated that Dr. Diamond had erroneously described appellant's condition as medial epicondylitis.

⁹ A.M.A., *Guides* 406.

grade modifier of one for physical examination, a mild problem; and a grade modifier of one for clinical studies, a mild problem, at Table 15-9, page 410.¹⁰ Pursuant to the formulas set forth at page 411 and Table 15-21, he then subtracted the grade modifier of one from functional history and clinical history, which yielded a total net adjustment of 0, for a grade C, one percent impairment of the left upper extremity based on a history of painful injury, residual symptoms without consistent objective findings; a surgical release of flexor or extensor origins with residual symptoms.

Dr. Berman discounted Dr. Diamond's rating for left ulnar nerve entrapment at the elbow, noting that this was not based on an accepted condition. Regarding impairment for left wrist de Quervain's tenosynovitis, he rated a one percent impairment pursuant to the wrist regional grid at Table 15-3, page 395 of the A.M.A., *Guides*, the table used for calculating upper extremity impairments based on the wrist.¹¹ Using this table, Dr. Berman rated a grade modifier of one for functional history pursuant to Table 15-7, page 406, a mild problem; and a grade modifier of one for physical examination under Table 15-8, page 408, a mild problem; and a grade modifier of one for clinical studies at Table 15-9, page 410. Pursuant to the formulas set forth at page 411 and Table 15-21, he then subtracted the grade modifier of one from functional history and physical examination, which yielded a net adjustment of zero, for a one percent impairment of the left upper extremity.

Dr. Diamond also rated a one percent right upper extremity impairment pursuant to the wrist regional grid at Table 15-3. He arrived at this rating by rendering the same findings for the right wrist that he calculated for the one percent impairment of the left wrist, above.

By decision dated February 13, 2013, OWCP granted appellant a schedule award for a one percent permanent impairment of the right upper extremity for the period April 28 to June 10, 2011, for a total of 6.24 weeks of compensation.

LEGAL PRECEDENT

The schedule award provision of FECA¹² and its implementing regulations¹³ 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.¹⁴ The claimant has the burden of proving

¹⁰ *Id.* at 410.

¹¹ *Id.* at 395.

¹² 5 U.S.C. § 8107.

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

¹⁴ *Id.*

that the condition for which a schedule award is sought is causally related to his or her employment.¹⁵

ANALYSIS

On appeal, counsel argues that there was a conflict of medical evidence between the opinions of Dr. Berman and Dr. Diamond which required referral to an impartial medical examiner regarding the proper degree of upper extremity impairment stemming from appellant's accepted conditions. He specifically contends that appellant was entitled to an impairment rating for left ulnar nerve entrapment; he argues that OWCP should have considered whether or not this was a preexisting condition or whether a diagnosis of left ulnar nerve entrapment should have been made.

The Board does not accept counsel's contentions. As noted above, it is appellant's burden to prove that the condition for which a schedule award is sought is causally related to her employment.¹⁶ The January 25, 2013 amended statement of accepted facts indicates that she had three accepted conditions: bilateral de Quervains tendinitis, left lateral elbow tendinitis and right forearm strain. Dr. Berman, OWCP's medical adviser, properly rendered his impairment rating based on these conditions, and relied on the findings Dr. Diamond issued in his April 6, 2010 report, in accordance with the applicable tables and protocols of the A.M.A., *Guides*. He reviewed Dr. Diamond's report and determined that appellant was only entitled to a one percent impairment for the left upper extremity for left lateral epicondylitis and a one percent impairment for the left and right wrist based on bilateral de Quervain's tenosynovitis. OWCP properly found that appellant did not have an impairment for left ulnar nerve entrapment at the elbow, as this was not an accepted condition.

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

“The impairment class 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

¹⁵ *Veronica Williams*, 56 ECAB 367, 370 (2005).

¹⁶ *Id.*

considered A; the highest possible grade is E, and adjustments greater than plus 2 will automatically be considered E. 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.”¹⁷

Using the formula above and the net adjustment formula outlined at pages 406 to 411 of the A.M.A., *Guides*, Dr. Berman found that appellant had a class 1 impairment for left lateral epicondylitis at Table 15-4, a class C impairment. He then applied the net adjustment formula at pages 406 and 410 of the A.M.A., *Guides*, finding that she had a grade of 1 for functional history and a grade of 1 for clinical history for an adjusted overall grade of zero, which resulted in a class C impairment; this yielded a one percent impairment of the left upper extremity.

With regards to an impairment for left and right wrist de Quervain’s tenosynovitis, Dr. Berman rated a one percent impairment under the wrist regional grid at Table 15-3, page 395 of the A.M.A., *Guides*. He rated a grade modifier of one for functional history, a grade modifier of one for physical examination and a grade modifier of one for clinical studies. Relying on the formulas outlined at page 411 and Table 15-21, Dr. Berman then subtracted the grade modifier of one from functional history and physical examination, which yielded a net adjustment of zero, for a class C, one percent impairment of the left and right upper extremities. As Dr. Berman provided the only impairment rating of record rendered in accordance with its applicable protocols and tables, OWCP properly granted a schedule award for a two percent impairment for the left upper extremity and a one percent impairment for the right upper extremity in its February 13, 2013 decision.¹⁸

Appellant may request an increased schedule award, at any time, 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 two percent permanent impairment of the left upper extremity and a one percent impairment for the right upper extremity, for which she received a schedule award.

¹⁷ A.M.A., *Guides* 387.

¹⁸ The Board notes that a description of appellant’s impairment must be obtained from her 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).

ORDER

IT IS HEREBY ORDERED THAT the February 13, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 18, 2014
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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