

OWCP authorized carpal tunnel surgery for bilateral carpal tunnel release. On May 20, 2009 appellant underwent left carpal tunnel release. On August 6, 2009 she underwent right carpal tunnel release.

In a September 25, 2013 diagnostic report, Dr. Harry Hughes, a Board-certified neurologist, reported that an electromyography (EMG) and nerve conduction velocity (NCV) study of the upper extremities revealed moderately severe bilateral median nerve injuries at the wrists affecting motor and sensory components, right worse than left. He noted that these findings could be due to residual abnormalities after appellant's prior carpal tunnel release. The study also revealed no evidence of ulnar nerve entrapment, mild chronic C5 and C6 motor radiculopathy on the right, and no evidence of acute right cervical motor radiculopathy.

In a February 3, 2014 medical report, Dr. Robert Gambrell, Board-certified in family medicine, reported that appellant underwent bilateral carpal tunnel release with positive results, but began to experience recurrent symptoms due to her repetitive employment activities. He noted that a recent EMG/NCV study of the upper extremities revealed moderately severe changes of both sensory and motor conduction. Dr. Gambrell provided findings on physical examination and diagnosed bilateral CTS: mononeuritis of the upper limb and mononeuritis multiplex. He opined that maximum medical improvement (MMI) had been reached.

Using the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),² Dr. Gambrell calculated nine percent bilateral upper extremity impairment based on Table 15-23 Entrapment/Compression Neuropathy Impairment,³ and the multiple simultaneous neuropathies section of the upper extremities chapter. According to Table 15-23 of the A.M.A., *Guides*, test findings were determined to be a grade modifier of 2 as shown by the motor conduction block from the recent EMG/NCV study. History was processed as a grade modifier of 2 due to significant intermittent symptoms. Dr. Gambrell noted that physical findings were relatively normal which placed appellant at a grade modifier of 1. Using the instructions for the rating process on page 448, he added the corresponding grade modifier values (2 + 2 + 1) and took the average of the sum, rounding to the nearest integer, for a total of 2 as the final grade modifier. Using the *QuickDASH* (QD) score of 55, Dr. Gambrell determined that appellant placed in the moderate level of the functional scale, which increased her upper extremity impairment rating to six percent for the right arm and six percent for the left arm. He then noted that, based on the multiple simultaneous neuropathy section, the nerve qualifying for the smaller impairment was rated at 50 percent of the impairment listed in Table 15-23, totaling an additional 3 percent impairment.⁴ Dr. Gambrell added the two nerve impairments for a total nine percent bilateral upper extremity impairment.⁵

On March 14, 2014 appellant filed a claim for a schedule award (Form CA-7).

² A.M.A., *Guides* (2009).

³ *Id.* at 449.

⁴ *Id.* at 448.

⁵ *Supra* note 3.

OWCP properly referred the case record to a district medical adviser (DMA) for review and a determination of whether appellant sustained a permanent partial impairment and the date of MMI. In his March 17, 2014 report, the DMA reported that appellant reached MMI on February 3, 2014, the date of Dr. Gambrell's evaluation. Utilizing Table 15-23 of the sixth edition of the A.M.A., *Guides*, the DMA noted that the grade modifiers for test findings, history, and physical findings totaled six, resulting in an average of two for the final grade modifier rating.⁶ The grade 2 modifier yielded a five percent impairment default value. After adjusting for a QD score of 55, the final impairment rating resulted in the higher value of six percent upper extremity impairment. The DMA noted that he agreed with Dr. Gambrell's final impairment rating for six percent upper extremity impairment of the right arm and six percent upper extremity impairment for the left arm.

By decision dated March 25, 2014, OWCP granted appellant a schedule award claim for six percent permanent impairment of the right arm and six percent permanent impairment of the left arm. The date of MMI was noted as February 3, 2014. The award covered a period of 37.44 weeks from February 3 to March 2, 2014. OWCP noted that the DMA agreed with Dr. Gambrell's six percent bilateral impairment calculation.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations 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.⁷ 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 scheduled losses.⁸

The A.M.A., *Guides* provide a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).⁹ Under the sixth edition, for upper extremity impairments the evaluator identifies the impairment Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).¹⁰ The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).¹¹

⁶ *Id.*

⁷ 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

⁸ *K.H.*, Docket No. 09-341 (issued December 30, 2011). For decisions issued after May 1, 2009, the sixth edition will be applied. *B.M.*, Docket No. 09-2231 (issued May 14, 2010).

⁹ A.M.A., *Guides*, *supra* note 2, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

¹⁰ *Id.* at 385-419.

¹¹ *Id.* at 411.

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.¹² In Table 15-23, grade modifier 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.¹³

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.¹⁴

ANALYSIS

OWCP accepted appellant's claim for bilateral CTS. The issue is whether appellant sustained more than six percent permanent impairment of the left arm and six percent permanent impairment of the right arm for which she received schedule awards. The Board finds that appellant has not met her burden of proof to establish that she has impairment of the right arm greater than six percent and impairment of the left arm greater than the six percent already awarded.

In a February 3, 2014 medical report, Dr. Gambrell reported that appellant's bilateral CTS had reached MMI. Using Table 15-23 of the A.M.A., *Guides*, he assigned a grade modifier of 2 for motor conduction block test findings, a grade modifier of 2 for history due to significant intermittent symptoms, and a grade modifier of 1 for relatively normal physical findings. The average of the three grade modifiers totaled 2 which was adjusted one value higher due to the moderate QD score of 55 on the functional scale. This resulted in six percent upper extremity impairment for the right arm and six percent upper extremity impairment for the left.

Dr. Gambrell then utilized the multiple simultaneous neuropathy section to calculate an additional 3 percent impairment, noting that the nerve qualifying for the smaller impairment was rated at 50 percent of the impairment listed in Table 15-23.¹⁵ Adding the six percent larger impairment value with the three percent smaller impairment value resulted in nine percent impairment of the upper extremity for the left and right.

The DMA reviewed Dr. Gambrell's report and averaged test findings, history, and physical findings as grade 2 for the final rating category. Using the 55 QD score¹⁶ under the functional scale, the DMA adjusted the default impairment rating of five percent to six percent

¹² *Id.* at 449.

¹³ *Id.* at 448-50.

¹⁴ See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

¹⁵ *Supra* note 4.

¹⁶ *Id.* at 449.

impairment of the upper extremity on the right and six percent impairment of the upper extremity on the left. The Board notes that the DMA properly reviewed Dr. Gambrell's report and agreed with his impairment rating of six percent right and six percent left impairment of the arms. The DMA, however, did not provide an additional three percent rating for multiple simultaneous neuropathies.

The A.M.A., *Guides* explain that, when multiple, concurrent neuropathies are diagnosed in the same limb; both impairments may be rated under Table 15-23.¹⁷ The nerve qualifying for the smaller impairment is rated at 50 percent of the impairment listed in Table 15-23, and then combined with the larger impairment rating. Nerve conduction testing of the upper limbs can clarify the role of the generalized peripheral nerve disease.¹⁸

Dr. Gambrell determined that 50 percent of the smaller impairment rating totaled 3 percent, which he added to the larger 6 percent impairment rating for a 9 percent total arm impairment. While he stated that appellant sustained multiple simultaneous neuropathies, he failed to specifically state what these other neuropathies were, nor did he provide any details on how he reached his impairment rating for the smaller impairment. Moreover, the most recent September 25, 2013 EMG/NCV study does not provide support for multiple simultaneous neuropathies as the study revealed moderately severe bilateral median nerve injuries at the wrists affecting motor and sensory components, no evidence of ulnar nerve entrapment, mild chronic C5 and C6 motor radiculopathy on the right, and no evidence of acute right cervical motor radiculopathy. Board precedent is well settled that when an attending physician's report gives an estimate of impairment but does not address how the estimate is based upon the A.M.A., *Guides*, OWCP may follow the advice of its DMA where he or she has properly applied the A.M.A., *Guides*.¹⁹ In this instance, Dr. Gambrell failed to adequately explain why appellant was entitled to an additional three percent impairment as a result of simultaneous neuropathies.

Accordingly, the Board finds that the DMA correctly applied the A.M.A., *Guides* in determining that appellant had a six percent permanent impairment of the right arm and six percent impairment of the left arm, for which she received a schedule award.²⁰

On appeal, appellant argues that Dr. Gambrell established that she was entitled to nine percent impairment of the bilateral upper extremities. The Board notes that it is appellant's burden of proof to establish that she sustained a permanent impairment of a scheduled member as a result of an employment injury.²¹ The medical evidence must include a description of any physical impairment in sufficient detail so that the claims examiner and others reviewing the file would be able to clearly visualize the impairment with its resulting restrictions and limitations.²²

¹⁷ *Id.* at 448.

¹⁸ *Id.*

¹⁹ See *Ronald J. Pavlik*, 33 ECAB 1596 (1982); *Robert R. Snow*, 33 ECAB 656 (1982); *Quincy E. Malone*, 31 ECAB 846 (1980).

²⁰ *J.S.*, Docket No. 12-1170 (issued November 9, 2012); *J.J.*, Docket No. 10-839 (issued December 23, 2010).

²¹ *Tammy L. Meehan*, 53 ECAB 229 (2001).

²² See *A.L.*, Docket No. 08-1730 (issued March 16, 2009).

Appellant has not submitted sufficient evidence to establish that she has more than six percent impairment for each of her arms and therefore OWCP properly awarded her six percent impairment for each arm.²³

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decision dated March 25, 2014 is affirmed.

Issued: January 15, 2015
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

²³ *V.W.*, Docket No. 09-2026 (issued February 16, 2010); *L.F.*, Docket No. 10-343 (issued November 29, 2010).