United States Department of Labor
Employees' Compensation Appeals Board

M.F., Appellant	)	
and	)	**Docket No. 09-1901**
	)	**Issued: July 1, 2010**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Kansas City, MO, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 20, 2009 appellant filed a timely appeal from an Office of Workers' Compensation Programs' decision dated July 2, 2009, which denied her claim for an additional schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision.

ISSUE

The issue is whether appellant has more than 12 percent permanent impairment of her right upper extremity and 6 percent impairment of her left upper extremity, for which she received a schedule award.

FACTUAL HISTORY

This case has twice previously been on appeal before the Board.[1] In a December 7, 2006 decision, the Board found that there was an unresolved conflict in the medical evidence with respect to whether appellant had an employment-related permanent impairment to her left arm entitling her to a schedule award.[2] In a January 28, 2008 decision, the Board set aside and remanded the Office's April 12 and June 28, 2007 schedule award decisions.[3] The Board found that the case was not in posture for decision regarding whether appellant had more than five percent impairment to her left arm, due to an unresolved conflict in the medical evidence. The Board found that the report from the impartial medical examiner did not fully explain whether there was an additional impairment for loss of elbow range of motion or motor deficit and remanded the case to the Office to obtain a report that properly resolved the issue. The facts and history contained in the prior appeals are incorporated by reference.

By letter dated February 5, 2008, the Office requested that Dr. M. Scot Beall, Jr., a Board-certified orthopedic surgeon, clarify his opinion with regard to the extent of appellant's impairment. In a February 14, 2008 report, Dr. Beall explained that, when he examined appellant, her range of motion was 10 degrees flexion and 95 degrees extension. He indicated that, when he observed appellant move, she had a full range of motion comparable to the other side and thus no impairment related to range of motion. Regarding appellant's motor deficit, Dr. Beall opined that he did not believe she had any impairment based on motor deficit related to the ulnar nerve transposition. He noted that the motor deficit or grip strength change that appellant had was related to the carpal tunnel syndrome.

By decision dated February 29, 2008, the Office denied appellant's claim for an additional schedule award to the left upper extremity.

Appellant requested reconsideration on March 13, 2008. She questioned Dr. Beall's rating, asserting that he did not clarify his findings. On March 27, 2008 Dr. Paul F. Nassab, a Board-certified orthopedic surgeon, advised that appellant had recurrent left carpal tunnel and left cubital tunnel with ulnar nerve entrapment at the elbow after sub-muscular transposition by significant fibro cartilage tissue. He performed a surgical repair.[4] By decision dated April 22, 2008, the Office denied modification of its prior decision.

On May 14, 2008 appellant requested reconsideration. She questioned the decision and the validity of Dr. Beall's report and noted that she had a left hand and elbow release on March 27, 2008.

In a May 31, 2008 report, the Office medical adviser noted Dr. Beall's explanation regarding appellant's measured range of motion, which he advised was severely limited when

[1] Docket No. 06-1174 (issued December 7, 2006) and Docket No. 07-1933 (issued January 28, 2009).

[2] The record reflects that appellant received a schedule award of 10 percent for the right arm on April 1, 2004.

[3] The record reflects that appellant received a schedule award of five percent to the left arm.

[4] He also performed a right carpal tunnel and right cubital tunnel release on January 10, 2008.

she knew she was being evaluated. He indicated that, when she was unaware that she was being observed, her range of motion improved vastly. The Office medical adviser explained that the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (5th ed. 2001) (A.M.A., *Guides*) precluded a rating for inconsistent and unreliable evaluation parameters. He concurred with Dr. Beall and advised that the physician correctly disregarded the measured range of motion. In a June 30, 2008 decision, the Office denied modification of its prior decision.

On October 8, 2008 appellant requested an additional schedule award.

By letter dated October 14, 2008, the Office advised appellant that additional evidence was needed to support her claim. An October 20, 2008 telephone call memorandum noted that appellant was claiming a schedule award for the right arm surgery done on January 10, 2008 and the left surgery performed on March 27, 2008.

In a December 16, 2008 report, Dr. Nassab, indicated that appellant had reached maximum medical improvement. He noted that she had an impairment of five percent for persistent palmar pain based on the A.M.A., *Guides* 495.

In a report dated January 19, 2009, the Office medical adviser noted that appellant was eligible for impairment ratings due to the right and left cubital tunnel syndromes and right and left carpal tunnel syndromes. He indicated that Dr. Nassab in his December 16, 2008 report indicated that appellant had five percent impairment for persistent palmar pain. The Office medical adviser found that this rating did not consider residuals of the surgically treated cubital tunnel syndromes. He indicated that additional documentation was needed for range of motion, pain and sensory deficits. The Office medical adviser recommended an evaluation by a physician skilled in the use of the A.M.A., *Guides,* to consider impairment ratings for permanent residuals of right and left cubital tunnel syndromes and right and left carpal tunnel syndromes.

On January 27, 2009 the Office referred appellant for a second opinion to Dr. George Varghese, Board-certified in physical medicine and rehabilitation. In a March 11, 2009 report, Dr. Varghese described appellant's history of injury and treatment and utilized the fifth edition of the A.M.A., *Guides.* He indicated that appellant had more pain symptoms involving the neck, back, shoulder and upper extremities and less symptoms from entrapment syndrome such as carpal tunnel syndrome and cubital tunnel syndrome. Dr. Varghese opined that these symptoms were most likely from her documented fibromyalgia diagnosis and degenerative joint disease. In rating right arm impairment, he noted that appellant had well-healed scars in the right wrist and elbow with no swelling or muscle atrophy. For right wrist range of motion, Dr. Varghese found two percent impairment for loss of flexion.

Regarding strength, Dr. Varghese advised that it was "give away" and that repeated testing revealed minimal weakness in the thenar eminence. He referred to provisions in the A.M.A., *Guides* for rating motor deficit and found one percent impairment for minimal loss of thenar strength. For loss of sensation in median nerve distribution, Dr. Varghese reported gross to normal two-point discrimination. He found that this sensory deficit represented four percent of the right arm. Dr. Varghese combined these values and found that appellant had seven percent impairment of the right arm due to recurrent carpal tunnel syndrome. Right elbow examination

showed a well-healed scar with no swelling or vasomotor changes. Appellant lacked 10 degrees of full elbow extension which equated to one percent arm impairment. There was no ratable loss of strength about the elbow as strength in the elbow flexion and extension was normal. Dr. Varghese found that appellant had a borderline sensory loss in two point discrimination testing and, applying the A.M.A., *Guides*, determined that appellant had one percent impairment of the right arm for sensory loss. He combined the values for the right arm and opined that appellant had total right arm impairment of nine percent.

For the left arm, Dr. Varghese noted a well-healed scar at the wrist. Appellant had normal strength and no vasomotor changes or muscle atrophy. Wrist and elbow range of motion findings were normal and warranted no impairment. For borderline sensory changes due to appellant's carpal tunnel syndrome, Dr. Varghese referred to tables in the A.M.A., *Guides* and determined that appellant had four percent left arm impairment. Regarding the left cubital tunnel release, he advised that no loss of strength was found. For sensory loss due to cubital tunnel syndrome, Dr. Varghese referred to the A.M.A., *Guides* and found one percent arm impairment. On range of motion testing, he noted measurements and opined that appellant had one percent impairment for minus 10 degrees of full extension. Dr. Varghese concluded that appellant had six percent left arm impairment. He advised that appellant reached maximum medical improvement on March 6, 2009. Dr. Varghese concluded that appellant had a permanent impairment rating of nine percent for the right upper extremity and six percent for the left upper extremity.

In a March 13, 2009 report, the Office medical adviser noted that appellant had already received a schedule award of five percent to the left upper extremity and 10 percent to the right upper extremity due to the carpal tunnel syndrome. He noted that the current rating from Dr. Varghese of seven percent for the right and four percent for the left carpal tunnel syndrome, was less than she had previously received and therefore she would not be entitled to an additional award for the carpal tunnel syndrome. Regarding her cubital tunnel syndrome, the Office medical adviser explained that appellant would be entitled to additional impairment of two percent for the right upper extremity and one percent for the left upper extremity.

In a March 20, 2009 decision, the Office granted appellant a schedule award for an additional two percent impairment of the right arm and one percent impairment of the left arm due to cubital tunnel syndrome. The award ran from March 6 to May 10, 2009.

On March 25, 2009 appellant requested a review of the written record. On April 1, 2009 the Office received an October 23, 2008 report from Dr. Nassab who opined that appellant reached maximum medical improvement. Dr. Nassab referred to the fourth edition of the A.M.A., *Guides* and recommended 10 percent impairment of the left arm. The Office also received his December 16, 2008 report, in which he opined that appellant reached maximum medical improvement and opined that appellant had five percent impairment of each arm for persistent pain based on the A.M.A., *Guides*.

In a May 12, 2009 decision, an Office hearing representative remanded the case. She found that the Office medical adviser did not fully explain his opinion and also noted that the sixth edition of the A.M.A., *Guides* should be used. The Office hearing representative directed

the Office medical adviser to apply Dr. Varghese's findings to the sixth edition of the A.M.A., *Guides*.

On June 5, 2009 the Office medical adviser utilized the sixth edition of the A.M.A., *Guides* and noted appellant's history. He noted that appellant reported sensory complaints which were not consistent with permanent residuals of a right or left carpal tunnel or cubital tunnel syndrome. For example, the Office medical adviser noted that appellant reported that her tingling and numbness were gone, but that she had pain all over the arm, especially in the biceps and triceps area as well as in the neck and shoulder. He concluded that appellant did not have any sensory symptoms caused by a carpal or cubital tunnel syndrome. The Office medical adviser further noted that the symptoms were not consistent with permanent sensory residuals of an entrapment neuropathy affecting the right arm. He also explained that appellant exhibited give away weakness on examination, which was consistent with a lack of full effort on volitional strength testing. The Office medical adviser also noted that, for both arms, appellant had two-point discrimination that was within the normal range. For cubital tunnel syndrome, he referred to Table 15-21[5] and noted that appellant would qualify as a Class 1 for impairment below the midforearm for the ulnar nerve. The Office medical adviser noted the impairment ratings ranged from zero to two percent. He explained that because appellant had no sensory deficits in either upper extremity the default value of one percent impairment was appropriate. The Office medical adviser further utilized the range of motion method. He noted that extension of minus 10 degrees at the right and left elbow levels would result in an impairment of one percent for each upper extremity.

Regarding carpal tunnel syndrome, the Office medical adviser also found that appellant was ratable as a Class 1 for her carpal tunnel syndrome. He noted the default value from Class 1 for a carpal tunnel syndrome was five percent for mild sensory loss. However, the Office medical adviser explained that the default value could only be utilized if there was a mild sensory deficit or mild complex regional pain symptoms (CRPS II) identified with objective findings. He determined the impairment rating of three percent was appropriate as appellant had no sensory deficit on examination. The Office medical adviser indicated that appellant no longer had numbness in either arm since the repeat operative procedures performed in 2008. He noted that the Quick Dash method did not apply as appellant's clinical history and examination findings were not "altogether credible."[6] The Office medical adviser opined that appellant had three percent impairment of the right and left arms for her carpal tunnel syndrome and one percent to the right and left arms for her cubital tunnel syndrome.

In a July 2, 2009 decision, the Office denied appellant's claim for an additional schedule award. It noted that she previously received awards that totaled 12 percent of her right arm and 6 percent of her left arm but that, under the sixth edition of the A.M.A., *Guides*, she would only be entitled to four percent permanent impairment rating for each arm.

[5] A.M.A., *Guides* 443.

[6] The Quick Dash method is a method utilized to determine disabilities of the arms, shoulders and hands using an activities of daily living questionnaire. However, if an individual has multiple answers that are not consistent it should not be used to assign impairment ratings. *See* A.M.A., *Guides* 482, 485.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[7] sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[8] The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[9] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[10] Effective May 1, 2009, the Office adopted the sixth edition of the A.M.A., *Guides*[11] as the appropriate edition for all awards issued after that date.[12]

ANALYSIS

In support of her claim for an increased schedule award, appellant submitted reports from Dr. Nassab dated October 23, and December 16, 2008. However, in his October 23, 2008 report, Dr. Nassab utilized the fourth edition of the A.M.A., *Guides* and in his December 16, 2008 report, he utilized the fifth edition of the A.M.A., *Guides.* As noted above, effective May 1, 2009, the Office adopted the sixth edition of the A.M.A., *Guides*[13] as the appropriate edition for all awards issued after that date. As the Office issued its decision on July 2, 2009, the sixth edition of the A.M.A., *Guides* is the appropriate edition. As these reports did not utilize the appropriate edition of the A.M.A., *Guides,* they are of limited probative value.

Under the sixth edition of the A.M.A., *Guides*, impairments of the upper extremities are covered by Chapter 15. Section 15-2, entitled *Diagnosis-Based Impairment*, indicates that "Diagnosis-based impairment is the primary method of evaluation of the upper limb."[14] The initial step in the evaluation process is to identify the impairment class by using the corresponding diagnosis-based regional grid. The Office medical adviser, as directed by the hearing representative, properly applied Dr. Varghese's findings from his March 11, 2009 report to the sixth edition of the A.M.A., *Guides.*

Regarding appellant's cubital tunnel syndrome, Dr. Varghese referred to Table 15-21, and noted that below the midforearm for the ulnar nerve would warrant a Class 1, for a default

[7] 5 U.S.C. §§ 8101-8193.

[8] *Id.* at § 8107.

[9] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[10] 20 C.F.R. § 10.404.

[11] A.M.A., *Guides* (6th ed. 2008).

[12] Federal (FECA) Procedure Manual, Part 3 -- Claims, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 9, 2010).

[13] *Id.*

[14] A.M.A., *Guides* 387, Section 15.2.

grade of C, or an impairment of one percent.[15] He noted that the impairment ratings ranged from zero to two percent. The Office medical adviser explained that because appellant had no sensory deficits in either upper extremity the default value of one percent was an appropriate impairment rating. For example, he noted that she advised that her tingling and numbness were gone but that she continued to have pain all over the arms. The Office medical adviser indicated that appellant reported that the numbness on both arms was not present since the repeat operative procedures in 2008. He also noted that appellant had give away weakness, which was an indicator of a lack of full effort in volitional strength testing. The Office medical adviser further explained that appellant's two-point discrimination findings for each arm fell within the normal range. After determining the impairment class and default grade, the next step in the process is to determine if there are any applicable grade adjustments for so-called "nonkey" factors or modifiers. These include adjustments for functional history (GMFH), physical examination (GMPE), and clinical studies (GMCS). The grade modifiers are used in the net adjustment formula to calculate a net adjustment.[16] The final impairment grade is determined by adjusting the grade up or down from the default value C by the calculated net adjustment. Because appellant had no sensory deficit in either upper extremity as a consequence of the cubital tunnel surgery, the Office medical adviser found the default value of one percent to be an appropriate impairment rating for each upper extremity.

Regarding appellant's carpal tunnel syndrome, the Office medical adviser referred to Table 15-21, for the median nerve below the midforearm and noted that appellant qualified for a Class 1, with a default grade of C, which represented five percent upper extremity impairment.[17] However, he determined that the default values for carpal tunnel syndrome could not be utilized as appellant had no sensory deficits on examination. The Office medical adviser also indicated that she no longer had numbness in either arm since the repeat operative procedures performed in 2008. He concluded that the best case scenario for appellant was an impairment of three percent for both her right and left carpal tunnel syndrome. Regarding the quick dash method, a tool for functional history adjustment, the Office medical adviser explained that it would not apply in appellant's situation as appellant's clinical history and examination findings were not "altogether credible."[18]

The Board finds that the Office medical adviser's rating is consistent with the provisions of the A.M.A., *Guides*. The Board also notes that the three percent for the carpal tunnel

[15] The grades range form A to E, with A and B representing zero (0) percent upper extremity impairment, C and D representing one (1) percent, and E representing two (2) percent upper extremity impairment. Table 15-21, A.M.A., *Guides* 443.

[16] Net Adjustment = (GMFH – CDX) + (GMPE – CDX) + (GMCS –CDX). Section 15.3d, A.M.A., *Guides* 411.

[17] The grades range from A to E, with A representing zero (0) percent upper extremity impairment, B and C representing three (3) percent and five (5) percent, D and E representing eight (8) percent and ten (10) percent. Table 15-21, A.M.A., *Guides* 438.

[18] *See supra* note 6. *See* A.M.A., *Guides* at 406 (if the functional history is determined to be unreliable or inconsistent with other documentation, it is excluded from the grading process).

syndrome combined with the one percent for the cubital tunnel syndrome would result in an impairment of four percent for each upper extremity.[19]

The Office medical adviser also rated, as an alternate method, appellant's impairment based on lost range of motion. However, the A.M.A., *Guides* provide that range of motion is used primarily as a physical diagnosis adjustment factor and only to determine actual impairment values when a grid permits its use as an option.[20] The Board notes that the grid used by the Office medical adviser, Table 15-21, does not indicate that range of motion may be used as a stand alone rating.

Accordingly, the Board finds that the evidence supports that, under the sixth edition of the A.M.A., *Guides,* appellant has no more than a four percent impairment of the right upper extremity and a four percent impairment of the left upper extremity. Appellant has not established entitlement to a schedule award greater than the previous awards of 12 percent to the right upper extremity and 6 percent to the left upper extremity.

On appeal appellant alleged that Dr. Varghese's higher rating should be utilized. She questioned why his report was initially accepted and then determined to be wrong. As noted, effective May 1, 2009, the sixth edition of the A.M.A., *Guides* is to be used. As the Office hearing representative, on May 12, 2009, directed a recalculation of the schedule award, the Office medical adviser properly applied Dr. Varghese's findings to the sixth edition of the A.M.A., *Guides*. There is no other evidence before the Board, conforming to the sixth edition of the A.M.A., *Guides*, showing any greater impairment.[21]

CONCLUSION

The Board finds that appellant does not have more than 12 percent impairment of her right upper extremity and 6 percent impairment of her left upper extremity.

[19] A.M.A., *Guides* 604.

[20] *Id.* at 387. *See also* A.M.A., *Guides* 461 (range of motion section is to be used as a stand-alone rating when other grids refer to the range of motion section or when no other diagnosis based estimate sections are applicable).

[21] After the Office's July 2, 2009 decision, appellant submitted additional evidence. However, the Board may not consider such evidence for the first time on appeal. 20 C.F.R. § 501.2(c); *James C. Campbell*, 5 ECAB 35 (1952).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated July 2, 2009 is affirmed, as modified.

Issued: July 1, 2010
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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