United States Department of Labor
Employees' Compensation Appeals Board

B.W., Appellant	)	
and	)	**Docket No. 11-2110**
	)	**Issued: April 12, 2012**
DEPARTMENT OF VETERANS AFFAIRS, JESSE BROWN MEDICAL CENTER, Chicago, IL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 21, 2011 appellant timely appealed the July 14, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP), which granted 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 greater than five percent impairment of the left upper extremity.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

Appellant, a 53-year-old program clerk, has an accepted traumatic injury claim for left ulnar neuritis, which arose on August 12, 2004.[2] On May 10, 2010 she filed a claim for a schedule award (Form CA-7). However, appellant did not submit an impairment rating. On May 24, 2010 OWCP advised her that she should have her physician submit an upper extremity impairment rating in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.

OWCP subsequently received a January 28, 2010 electromyogram and nerve conduction study (EMG/NCV), and a June 7, 2011 report from Jacob Salomon, M.D., who interpreted appellant's latest EMG/NCV as revealing bilateral carpal tunnel syndrome and left cubital tunnel syndrome.[3] It also received an August 3, 2010 referral from Dr. Victor M. Romano, a Board-certified orthopedic surgeon, who diagnosed reflex sympathetic dystrophy and referred appellant for a functional capacity evaluation. Lastly, OWCP received an August 12, 2010 functional capacity evaluation (FCE) from Al Flores, a physical therapist, who found 25 percent left upper extremity (LUE) impairment due to complex regional pain syndrome/reflex sympathetic dystrophy (CRPS/RDS).[4]

Dr. David H. Garelick, a Board-certified orthopedic surgeon and district medical adviser (DMA), reviewed the claim on June 20, 2011. The DMA disagreed with Mr. Flores' 25 percent LUE impairment rating. He also disagreed with the diagnosis of CRPS/RDS because such a diagnosis was not supported by the evidence. The DMA rated appellant under Table 15-23 (Entrapment/Compression Neuropathy), A.M.A., *Guides* 449 (6th ed.), which provided for a maximum upper extremity impairment of nine percent. He noted that appellant continued to complain of constant pain in the left arm with intermittent paresthesias. The DMA also noted that physical examination demonstrated full range of motion in the wrist and elbow and there was no mention of any loss of sensation. He further indicated that there was no apparent loss of strength or atrophy noted in the upper extremity. The DMA also noted that appellant's latest upper extremity EMG demonstrated moderate left ulnar nerve neuropathy.

Under Table 15-23, the DMA found a grade 2 modifier for appellant's EMG results (Test Findings), a grade 3 modifier for her reported "constant symptoms" (History), and a grade 1 modifier for her "unremarkable" physical examination (Physical Findings). The average of the above-noted grade modifiers was 2 (2+3+1=6÷3=2), which represented a default upper extremity impairment of five percent under Table 15-23. The DMA did not make any additional adjustment for functional scale presumably because a *Quick*DASH (Disabilities of the Arm,

[2] She was injured when she fell from a broken office chair.

[3] A prior EMG/NCV dated March 18, 2005 did not reveal carpal tunnel syndrome.

[4] Table 15-26 (Complex Regional Pain Syndrome), A.M.A., *Guides* 454 (6th ed.).

Shoulder and Hand) assessment had not been provided.[5] Thus, the DMA found five percent impairment of the left upper extremity, with a February 12, 2005 date of maximum medical improvement (MMI).[6]

By decision dated July 14, 2011, OWCP granted a schedule award for five percent impairment of the left upper extremity. The award covered a period of 15.6 weeks from February 12 to June 1, 2005.

LEGAL PRECEDENT

Section 8107 of FECA 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.[7] FECA, 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 under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[8] Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides*.[9]

ANALYSIS

Certain healthcare providers such as physician assistants, nurse practitioners and physical therapists are not considered "physician[s]," as that term is defined under FECA.[10] As such, their medical findings and/or opinions will not suffice for purposes of establishing entitlement under FECA.[11] Consequently, as a physical therapist, Mr. Flores is not deemed competent under FECA to offer a medical opinion regarding the nature and extent of appellant's upper extremity impairment pursuant to the A.M.A., *Guides* (6th ed.).[12] Based on a diagnosis of CRPS/RDS,

[5] The *Quick*DASH consists of 11 questions regarding one's upper extremity symptoms (pain/tingling/difficulty sleeping) and the ability to perform certain activities such as opening a tight or new jar or using a knife to cut food. *See* Table 15-39, A.M.A., *Guides* 485 (6th ed.). Based on the individual responses, a score is calculated from 0-100. The *Quick*DASH score is then used to determine what, if any, additional modification should be made based on functional scale. Table 15-23, A.M.A., *Guides* 449 (6th ed.).

[6] He explained that MMI would have occurred approximately six months after appellant's August 12, 2004 work-related fall.

[7] For a total, or 100 percent loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1).

[8] 20 C.F.R. § 10.404 (2011).

[9] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6a (January 2010).

[10] 5 U.S.C. § 8101(2); 20 C.F.R. § 10.5(t).

[11] *David P. Sawchuk*, 57 ECAB 316, 320 n.11 (2006).

[12] *Id.*

Mr. Flores found 25 percent left upper extremity impairment under Table 15-26, A.M.A., *Guides* 454 (6th ed.). The DMA disagreed with the diagnosis of CRPS/RSD because it was not supported by the record. Although Dr. Romano's August 3, 2010 referral included a diagnosis of RSD, he did not provide any justification for this diagnosis. In contrast, Dr. Salomon noted in his June 7, 2011 report that appellant's latest objective studies revealed left cubital tunnel syndrome and bilateral carpal tunnel syndrome (CTS).[13] The DMA properly rated appellant based on her accepted left cubital tunnel syndrome (ulnar neuritis).[14]

While appellant challenges OWCP's award of five percent impairment of the left upper extremity, she has not submitted any probative medical evidence indicating she has a greater impairment than previously awarded. Dr. Garelick, the DMA, reviewed the record, including the August 12, 2010 FCE results, and found that appellant had five percent impairment of the LUE. He explained that, under Table 15-23, A.M.A., *Guides* 449 (6th ed.), appellant's grade modifiers for test findings (2), history (3) and physical findings (1) totaled 6, which represented an average grade modifier of 2. A grade 2 modifier corresponds to a default upper extremity impairment rating of five percent. Because a *Quick*DASH score had not been provided, there was no basis for further adjustment under Table 15-23. Thus, the default rating of five percent represented appellant's LUE impairment. The DMA's June 20, 2011 impairment rating conforms to the A.M.A., *Guides* (6th ed.), and thus, represents the weight of the medical evidence regarding the extent of appellant's LUE impairment.

CONCLUSION

Appellant failed to establish she has greater than five percent impairment of the left upper extremity.

[13] The Board notes that CTS is not an accepted condition under the current claim, and based on the previous EMG/NCV dated March 18, 2005, this condition did not predate appellant's August 12, 2004 employment injury. While Dr. Salomon encouraged OWCP to include bilateral CTS as part of the current claim, he offered no explanation as to how this condition was causally related to appellant's accepted left upper extremity employment injury.

[14] Not all impairments to a schedule member need be employment related. Under certain circumstances, previous impairments may be included in calculating the percentage of loss. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.7a(2) (January 2010); *see R.D.*, 59 ECAB 127, 130 (2007). Appellant's CTS has not been proven to be employment related and there is no definitive evidence that this condition predated the accepted August 12, 2004 traumatic injury.

ORDER

IT IS HEREBY ORDERED THAT the July 14, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 12, 2012
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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