United States Department of Labor
Employees' Compensation Appeals Board

J.W., Appellant	)	
and	)	**Docket No. 12-653**
	)	**Issued: August 10, 2012**
U.S. POSTAL SERVICE, POST OFFICE, Douglas, GA, 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
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On February 7, 2012 appellant timely appealed the January 18, 2012 nonmerit decision of the Office of Workers' Compensation Programs (OWCP) denying his request for reconsideration and an October 27, 2011 decision 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.[2]

ISSUES

The issues are: (1) whether appellant established that he has more than four percent impairment to each upper extremity; and (2) whether OWCP denied merit review on January 18, 2012.

[1] 5 U.S.C. §§ 8101-8193.

[2] The Board notes that, following the issuance of the January 18, 2012 OWCP decision, appellant submitted new evidence. However, the Board is precluded from reviewing evidence which was not before OWCP at the time it issued its final merit decision. *See* 20 C.F.R. § 501.2(c)(1). Appellant may resubmit this evidence, together with a written request for reconsideration to OWCP, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. § 10.606.

FACTUAL HISTORY

On April 29, 1992 appellant, then a 36-year-old letter carrier, filed a claim of occupational disease, alleging that he developed a bilateral wrist condition as a result of his federal duties. His claim was accepted by OWCP for bilateral carpal tunnel syndrome. Appellant underwent a right carpal tunnel release on November 11, 1992 and a left carpal tunnel release on December 15, 1992.

On October 12, 2001 appellant retired from his position as a letter carrier. On April 22, 2011 he filed a claim for schedule award.

On April 29, 2011 OWCP referred appellant's case to Dr. Douglas Hein, a Board-certified specialist in orthopedic surgery, for a second opinion evaluation to determine if he had residuals from his accepted condition or any impairment of his upper extremities.

In a June 13, 2011 medical report, Dr. Hein stated that appellant had possible recurrent carpal tunnel syndrome of both hands, which appeared to be residuals from his accepted condition of bilateral carpal tunnel syndrome. He related that an impairment rating could not be given because appellant was not at maximum medical improvement as his condition could be improved if he underwent a secondary release.

On July 5, 2011 OWCP referred appellant to Dr. Charles W. Griffin, a Board-certified specialist in diagnostics, for updated testing.

In a report dated July 18, 2011, Dr. Griffin diagnosed bilateral moderate to severe carpal tunnel syndrome and moderate right ulnar neuropathy at the wrist. He noted that appellant's right median palmar sensory nerve had a low amplitude and prolonged distal latency, his left median palmar sensory nerve had a prolonged distal latency, his right ulnar sensory nerve had a prolonged distal latency and that his median motor nerves have prolonged distal latencies.

In a July 27, 2011 report, Dr. Hein reviewed the electrodiagnostic studies which showed bilateral moderate to severe carpal tunnel syndrome and right ulnar neuropathy of moderate severity. He concluded that the findings were either recurrent or residual and that appellant had potential for further improvement if the conditions were surgically addressed.

By letter dated August 12, 2011, OWCP advised appellant that additional action would not be taken regarding his schedule award claim until he submitted medical evidence that he had reached maximum medical improvement.

Appellant submitted an August 31, 2011 report from Dr. James W. Fordyce, an osteopathic physician Board-certified in orthopedic surgery. Dr. Fordyce noted that appellant had no numbness or tingling at anytime of the day or night, had no pain in the forearm, wrist or hand at anytime day or night. He did note appellant's complaint that the sensitivity of his touch was "not as acute." Dr. Fordyce related that while appellant may have had a little deficit in his sensation which had been present for all these years, he did not realize it until he started working again. The level of symptoms appellant currently did not warrant carpal tunnel surgery of either hand. Dr. Fordyce stated that appellant had absolutely no ulnar nerve symptoms at the wrist and negative canal of the Guyon's canal of either wrist. He concluded that appellant might consider

bracing at nighttime or a carpal tunnel steroid injection, but recommended against additional surgery.

On September 15, 2011 OWCP's medical adviser reviewed the medical evidence and concluded that appellant had reached maximum medical improvement on August 31, 2011, based on the report of Dr. Fordyce. Based on Table 15-23 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), appellant's condition rated a "grade modifier total 5," and average 1.66 which rounded to 2 after rounding. The medical adviser stated that grade modifier 2 was selected with a default of five percent upper extremity impairment, however since no *Quick*DASH score was provided, the lowest upper extremity impairment for that modifier should be selected, resulting in a final impairment rating of four percent in each arm.

On October 27, 2011 OWCP granted schedule awards for four percent permanent impairment to each. The awards covered a period of 19.52 weeks from August 31, 2011 to January 14, 2012.

OWCP received further documents on November 17, 2011 including surgical reports from October and December 1992, medical reports pertaining to other health conditions and copies of Dr. Griffin's July 18, 2011 report.

Appellant filed for reconsideration in a January 3, 2012 letter, stating that he had new medical evidence to establish his impairment rating. OWCP did not receive further medical evidence. In a January 18, 2012 decision, it denied appellant's request for reconsideration without merit review.

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.[3] 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.[4] Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides*.[5]

[3] 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).

[4] 20 C.F.R. § 10.404.

[5] *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).

The sixth edition of the A.M.A., *Guides*,[6] provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[7] Under the sixth edition, for upper extremity impairments the evaluator identifies 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).[9]

ANALYSIS

In determining appellant's impairment rating, the district medical adviser applied the physical findings of the medical reports to Table 15-23 of the A.M.A., *Guides*, sixth edition.[10] He initially noted "grade modifier total 5 and average 1.66 raised to 2." The Board notes that pursuant to Table 15-23, modification is based upon test findings, history, physical findings and functional scale. The district medical adviser did not explain how he totaled five for a modifier based upon these criteria. He then placed appellant's impairment in the category of a grade modifier 2. To be placed in the category of grade modifier 2, test findings must document motor conduction block, history must document significant intermittent symptoms, physical findings must document decreased sensation and appellant's functional scale must be rated. The Board notes that the findings of record from Dr. Griffin's July 18, 2011 report document conduction delay, but did not establish motor condition block. Appellant's history, as reported by his treating physician, Dr. Fordyce did not document any history of symptoms such as numbness, tingling or pain. Dr. Fordyce only noted that the sensitivity of his touch was "not as acute." The default impairment value could be modified up or down based on the functional scale grade or the *Quick*DASH score.[11] However, the district medical adviser went on to select four percent as the final impairment rating to each upper extremity, because no *Quick*DASH score was provided by the attending physician. The Board has held that when no *Quick*DASH score had been provided there was no basis for further adjustment under Table 15-23.[12] As such, the district medical adviser improperly deducted appellant's impairment rating percentage based on a lack of *Quick*DASH score.

The Board has held that in providing a permanent impairment rating, a description of appellant's impairment must be obtained which is in sufficient detail so that the claims examiner and others reviewing the file will be able to visualize the impairment with its resulting

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

[7] *Id*. at section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

[8] *Id.* at 385-419.

[9] *Id*. at 411.

[10] *Id*. at 449, 454 (6th ed. 2008). Section 15.4f, Entrapment Neuropathy.

[11] *Id*.

[12] *B.W.*, Docket No. 11-2110 (issued April 12, 2012).

restrictions and limitations.[13] As the Board is unable to accurately visualize appellant's impairment based on the district medical adviser's report, the case will be remanded to OWCP. After such further development as necessary, OWCP shall issue a *de novo* decision on appellant's schedule award claim.[14]

CONCLUSION

The Board finds that the case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the October 27, 2011 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for proceedings consistent with this order of the Board.

Issued: August 10, 2012
Washington, DC

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

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

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

[13] *See Renee M. Straubinger*, 51 ECAB 667 (2000).

[14] The January 18, 2012 nonmerit decision is mooted by this remand.