United States Department of Labor
Employees' Compensation Appeals Board

J.Y., Appellant	)	
and	)	**Docket No. 12-131**
	)	**Issued: July 18, 2012**
U.S. POSTAL SERVICE, POST OFFICE, Gig Harbor, WA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 24, 2011 appellant filed a timely appeal from a September 23, 2011 schedule award decision of the Office of Workers' Compensation Programs (OWCP). 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 schedule award issue.

ISSUE

The issue is whether appellant sustained employment-related permanent impairment of her left arm or more than a one percent permanent impairment of the right arm for which she received a schedule award.

FACTUAL HISTORY

On February 14, 1992 appellant, then a 41-year-old rural carrier, injured her left hand while in the performance of duty. OWCP accepted her claim, assigned File No. xxxxxx353, for

[1] 5 U.S.C. § 8101 *et seq.*

left wrist strain and de Quervain's syndrome.[2] On June 8, 1992 appellant sustained a right wrist condition on the job. OWCP accepted her claim, assigned File No. xxxxxx499, for right wrist ganglion cyst and subsequently expanded it to include right de Quervain's tenosynovitis.[3] Appellant returned to modified duty effective June 28, 1993. On December 2, 1994 OWCP issued a schedule award for one percent permanent impairment of the right arm, due to loss of wrist range of motion.

On August 20, 2000 appellant filed a Form CA-2 alleging that she developed an occupational disease due to shoulder overuse. OWCP accepted her claim, assigned File No. xxxxxx414,[4] for bilateral shoulder tendinitis. It later accepted a January 8, 2003 claim for recurrence of disability arising on November 23, 2003.[5] Appellant elected disability retirement effective January 3, 2004.[6]

September 1, 2004 bilateral shoulder x-rays obtained by Dr. George A. Weis, a Board-certified diagnostic radiologist, did not show any fractures, dislocations or periarticular soft tissue calcifications. In a September 11, 2004 report, Dr. Patrick N. Bays, an osteopath specializing in orthopedic surgeon, observed negative bilateral impingement, apprehension and glenohumeral compression signs on examination. He also noted a negative Finkelstein's test for bilateral de Quervain's tenosynovitis. In view of the objective findings, Dr. Bays opined that appellant's bilateral shoulder tendinitis resolved and her subjective complaints of pain were "out of proportion."

In a March 3, 2005 report, Dr. William T. Thieme, a Board-certified orthopedic surgeon, evaluated appellant's shoulders and found normal passive range of motion (ROM), globalized tenderness and nonphysiological behavior during active motor strength and sensation assessments. He concluded that the bilateral shoulder tendinitis resolved, explaining that the condition normally entailed tenderness of specific tendons and resolved with conservative care after six to eight weeks. In a report dated September 6 and 7, 2007, Dr. Richard E. Hall, a Board-certified orthopedic surgeon, tested appellant's acromioclavicular and glenohumeral joints for impingement, Yergason's, Speed's and O'Brien's and Hawkins' signs, all of which were negative. He also elicited a negative Phalen's test maneuver for carpal tunnel syndrome and a

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[2] Appellant underwent left wrist tendon release on February 12, 1993.

[3] During right volar wrist surgery on November 2, 1992, Dr. Neville A. Lewis, a Board-certified orthopedic surgeon, indicated that he was unable to locate the cyst. Appellant later underwent right wrist tendon release on June 28, 1996.

[4] OWCP combined all claims into File No. xxxxxx414, which was designated as the master file.

[5] In an August 1, 2005 decision, OWCP terminated appellant's compensation benefits effective August 6, 2005. On September 14, 2006 OWCP's hearing representative remanded the case for further medical development regarding whether appellant sustained fibromyalgia as a result of her federal employment. By decision dated January 24, 2008, OWCP determined that the condition was nonindustrial. Appellant filed a request for reconsideration, which was denied on February 19, 2009 because she did not present new evidence or legal contentions warranting further merit review. This matter is not presently before the Board.

[6] The foregoing information was incorporated into the March 9, 2010 statement of accepted facts.

negative Froment's sign for ulnar nerve palsy. Dr. Hall opined that appellant's multiple upper extremity injuries "appear to be resolved."

Dr. Peter Mohai, a Board-certified internist, remarked in a November 20, 2007 report that appellant was guarded throughout physical examination as she exhibited "give way" reactions during bilateral shoulder abduction and external rotation, elbow flexion and Finkelstein's testing. He noted the absence of swelling or inflammation of the bilateral hand and elbow joints. Dr. Mohai concluded that the objective findings did not substantiate an "active disease."

Appellant filed a claim for a schedule award on July 13, 2009.

In a March 9, 2009 report, Dr. John W. Ellis, a Board-certified family practitioner, reviewed the history of injury and medical evidence. On examination, he observed bilateral biceps tendon, acromioclavicular joint and cubital tunnel tenderness, medial and lateral humeral epicondyle hypertrophy and limited shoulder, wrist and thumb ROM. Dr. Ellis also detected posterior cervical, shoulder girdle and thoracic paraspinal muscle tightness and slight trapezius muscle paresthesia. Percussion over the median nerve at both wrists and the ulnar nerve at both elbows revealed positive Tinel's signs. Dr. Ellis elicited diminished biceps reflexes, but not wrist or triceps reflexes. He diagnosed bilateral shoulder tendinitis and traumatic arthritis, brachial plexus impingement, medial and lateral epicondylitis with ulnar nerve impingement, cubital tunnel syndrome, de Quervain's stenosing tenosynovitis, carpal tunnel syndrome and trigger thumb and confirmed that the right wrist ganglion cyst resolved. Dr. Ellis opined that appellant's federal employment caused each condition and determined that she had 35 percent permanent impairment of the right arm and 29 percent permanent impairment of the left arm.[7] He identified January 3, 2004 as the date of maximum medical improvement.

OWCP informed appellant in a July 27, 2009 letter that additional information was needed to establish her claim, specifying that an impairment rating report must utilize the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*).[8]

In an amended March 9, 2009 report,[9] Dr. Ellis cited Table 15-2 (Digit Regional Grid),[10] Table 15-3 (Wrist Regional Grid)[11] and Table 15-4 (Elbow Regional Grid)[12] of the sixth edition of the A.M.A., *Guides* and assigned impairment ratings of 8 percent for right thumb carpometacarpal joint arthritis, 10 percent for right wrist surgery and 1 percent for right elbow pain, respectively. He stated that he arrived at these figures after he calculated a net adjustment of two for Functional History (GMFH) and Physical Examination (GMPE). Regarding the left

[7] Dr. Ellis based these figures on the fifth edition of the A.M.A., *Guides*. *Contra infra* note 8.

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

[9] Aside from the revised impairment ratings, the rest of Dr. Ellis' report remained unchanged.

[10] *See id.* at 391-94.

[11] *See id.* at 395-97.

[12] *See id.* at 398-400.

hand, Dr. Ellis assigned impairment ratings of two percent for index finger stenosing and extensor tendon ganglion, three percent for wrist ganglion and nine percent for traumatic arthritis based on Table 15-2 and Table 15-3. He attributed an additional six percent to left carpal tunnel syndrome.[13] Dr. Ellis concluded that appellant sustained 18 percent permanent impairment of the right upper extremity and 19 percent permanent impairment of the left upper extremity.[14]

On March 11, 2010 OWCP's medical adviser reviewed Dr. Ellis' original March 9, 2009 report based on the fifth edition of the A.M.A., *Guides* and disagreed with his impairment ratings. He asserted that the medical evidence, namely the reports from Drs. Bays, Hall, Mohai and Thieme, indicated that appellant's bilateral shoulder tendinitis resolved and her other accepted conditions were treated surgically.

OWCP found that a conflict in medical opinion existed between Dr. Ellis and its medical adviser regarding whether appellant had permanent impairment of her upper extremities. It referred appellant for a referee examination to Dr. Allen W. Jackson, a Board-certified orthopedic surgeon. In a report dated April 23 and June 7, 2010, Dr. Jackson reviewed the March 9, 2010 statement of accepted facts and medical file. On examination, he observed limited scapular retraction and protraction and bilateral shoulder ROM. June 3, 2010 magnetic resonance imaging (MRI) scans of the shoulders exhibited bilateral subacromial-subdeltoid bursitis and acromioclavicular joint osteoarthritis as well as right glenohumeral osteoarthritis. Dr. Jackson opined that the objective findings did not demonstrate any permanent impairment due to the accepted conditions, pointing out that the MRI scan results suggested that appellant's bilateral shoulder symptoms were nonphysiological.

By decision dated June 15, 2010, OWCP denied appellant's claim for a schedule award, finding the evidence insufficient to demonstrate that she sustained a measurable impairment of a scheduled member due to an accepted condition. On March 17, 2011 following a November 3, 2010 telephonic hearing, OWCP's hearing representative vacated the decision and remanded the case for further medical development.[15]

OWCP referred appellant for a second opinion examination to Dr. Aleksandar Curcin, a Board-certified orthopedic surgeon. In an August 13, 2011 report, Dr. Curcin conducted a physical evaluation and observed full deltoid, biceps, external and internal rotator and supraspinatus muscle strength and the absence of any asymmetry or atrophy. He noted that appellant was "self-limited" during bilateral wrist and shoulder ROM maneuvers and dynamometer grip strength testing. Although appellant stated that her left hand fingers were in a

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[13] While Dr. Ellis referred to an "attached worksheet" to corroborate this additional amount, the case record does not contain such a document.

[14] In the alternative, Dr. Ellis listed impairment ratings of 10 percent for each upper extremity on account of decreased wrist ROM.

[15] OWCP's hearing representative found that OWCP erroneously determined that a conflict in medical opinion existed between Dr. Ellis and its medical adviser because the latter's March 11, 2010 report was of lesser weight. She then considered Dr. Jackson's report dated April 23 and June 7, 2010 for its own intrinsic value and concluded that it was insufficient to constitute the weight of the medical evidence. The hearing representative directed that OWCP obtain clarification from Dr. Jackson. Although OWCP sought clarification from Dr. Jackson, who did not respond to OWCP's request.

stuck position after dynamometer testing, Dr. Curcin saw no evidence of trigger finger in that hand. Two-point discrimination of the bilateral upper extremities was deemed unreliable: after appellant initially provided ambiguous responses, further coaxing revealed recognition of two points separated by eight millimeters on the bilateral ulnar nerves and left median nerve. Appellant did not report right median nerve sensation. After reviewing the March 9, 2010 statement of accepted facts and medical file, Dr. Curcin opined that the objective evidence did not establish that she sustained permanent bilateral upper extremity impairment as a result of her accepted conditions. He specified that appellant's bilateral de Quervain's tenosynovitis postoperatively resolved and that, prior radiological results, namely the June 3, 2010 MRI scan, merely showed age-related osteoarthritic changes in the shoulders. Dr. Curcin determined that an impairment rating based on the A.M.A., *Guides* was inappropriate in view of his findings as well as appellant's self-limiting behavior during the examination. He also reiterated that x-rays and MRI scans failed to reveal any substantive pathology and that electrodiagnostic studies of the arms refuted appellant's assertions of numbness and inability to discriminate two-point sensation.

By decision dated September 23, 2011, OWCP denied appellant's claim for a schedule award of the upper extremities.

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 of or loss of use of scheduled members or functions of the body.[16] 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.[17]

The A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF). 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). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[18] Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[19]

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[16] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[17] *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).

[18] *R.Z.*, Docket No. 10-1915 (issued May 19, 2011).

[19] *J.W.*, Docket No. 11-289 (issued September 12, 2011).

ANALYSIS

The Board finds that Dr. Curcin's August 13, 2011 report constitutes the weight of the medical evidence.

The weight of the medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion.[20] After filing a July 13, 2009 claim for a schedule award, appellant furnished two reports from Dr. Ellis, both of which were dated March 9, 2009. The original report calculated 35 percent permanent impairment of the right upper extremity and 29 percent permanent impairment of the left upper extremity based on the fifth edition of the A.M.A., *Guides*. The Board has held that the fifth edition applies to schedule award decisions issued between February 1, 2001 and April 30, 2009 while the sixth edition applies to decisions issued on or after May 1, 2009.[21] Because Dr. Ellis did not utilize the proper edition of the A.M.A., *Guides*, the original report was of diminished probative value.[22]

After OWCP instructed an impairment rating report in accordance with the sixth edition of the A.M.A., *Guides*, Dr. Ellis provided an amended March 9, 2009 report containing updated ratings. For the left arm, in which no impairment has been accepted, the Board must first review whether the impairment of the scheduled member is causally related to an accepted work injury before application of the A.M.A., *Guides*.[23] In this case, OWCP accepted appellant's claims for left wrist strain, right wrist ganglion cyst, bilateral de Quervain's tenosynovitis and bilateral shoulder tendinitis. While Dr. Ellis diagnosed bilateral shoulder tendinitis, he did not attribute any impairment to this condition. He calculated impairment of 19 percent on account of index finger stenosing and extensor tendon ganglion, wrist ganglion, traumatic arthritis and carpal tunnel syndrome. OWCP, however, did not accept any of these as industrial injuries such that impairment attributable to these conditions is not compensable.

With regards to the right upper extremity, as noted, OWCP issued appellant a schedule award for one percent permanent impairment of the right arm on December 2, 1994. It is well established that in determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.[24] However, while Dr. Ellis confirmed that the right wrist ganglion cyst resolved and found 18 percent impairment due to carpometacarpal joint arthritis of the thumb, elbow pain and wrist surgery, he did not explain whether any of the nonaccepted conditions, thumb arthritis or elbow pain, preexisted appellant's work injuries. Thus, with respect to nonindustrial conditions, appellant is not eligible for a schedule award in the absence

[20] *I.R.*, Docket No. 09-1229 (issued February 24, 2010); *James Mack*, 43 ECAB 321, 329 (1991).

[21] *See B.M.*, *supra* note 17.

[22] *A.B.*, Docket No. 10-2124 (issued August 10, 2011). *See also James Kennedy, Jr.*, 40 ECAB 620, 627 (1989) (an opinion that is not based upon standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of permanent impairment).

[23] *R.A.*, Docket No. 08-1301 (issued March 5, 2009); *Veronica Williams*, 56 ECAB 367, 370 (2005).

[24] *Peter C. Belkind*, 56 ECAB 580, 586 (2005).

of evidence establishing that these conditions preexisted the accepted conditions. As noted, she underwent wrist tendon release for her accepted right de Quervain's tenosynovitis, to which Dr. Ellis appeared to allocate 10 percent of his right arm impairment rating. According to OWCP procedures, an attending physician's impairment rating report must include a detailed description of the impairment and a rationalized opinion as to the percentage of permanent impairment under the A.M.A., *Guides*.[25] Here, Dr. Ellis cited the Table 15-3 regional grid, but did not identify the impairment class for the CDX. He then remarked that he calculated a net adjustment of two for GMFH and GMPE, but did not explain how he calculated each grade modifier score or use the net adjustment formula.[26] Because Dr. Ellis' ratings did not comport with the standards of the A.M.A., *Guides*, his amended report is of limited probative value on the extent of appellant's right upper extremity impairment.[27]

In an August 13, 2011 report, Dr. Curcin reviewed the statement of accepted facts and medical file and conducted an extensive physical examination, which included two-point discrimination and dynamometer grip strength testing. He opined that appellant did not sustain any additional permanent impairment resulting from the accepted left wrist strain, right wrist ganglion cyst, bilateral de Quervain's tenosynovitis or bilateral shoulder tendinitis. Dr. Curcin detailed that a recent June 3, 2010 MRI scan exhibited shoulder osteoarthritis that was indicative of aging, the clinical findings and evidence of record showed that the bilateral wrist and thumb conditions resolved and appellant acted uncooperatively during the examination with self-limiting behavior. Based on his current findings and review of the record, he determined that there was no objective basis on which to rate permanent impairment of either upper extremity. In view of this rationalized medical opinion, the Board finds that OWCP properly denied appellant's claim.

Appellant argues on appeal that the September 23, 2011 decision is contrary to the facts and law. As explained, the Board has addressed the deficiencies of her claim. Appellant may request a schedule award or increased schedule award 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 not sustained any employment-related impairment of the left arm and has not sustained more than one percent permanent impairment of the right arm for which she previously received a schedule award.

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[25] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6(a)-(c) (January 2010).

[26] *See J.H.*, Docket No. 10-1927 (issued June 1, 2011). *See* A.M.A., *Guides* at 411-12 (describes the method for determining impairment).

[27] *See Linda Beale*, 57 ECAB 429 (2006) (it is well established that, when the attending physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides*, his or her opinion is of diminished probative value in establishing the degree of permanent impairment).

ORDER

IT IS HEREBY ORDERED THAT the September 23, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 18, 2012
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

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