United States Department of Labor
Employees' Compensation Appeals Board

R.M., Appellant	)	
and	)	**Docket No. 12-255**
	)	**Issued: June 19, 2012**
U.S. POSTAL SERVICE, POST OFFICE, Fayetteville, AR, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 17, 2011 appellant filed a timely appeal from an August 15, 2011 schedule award decision of the Office of Workers' Compensation Programs (OWCP) and a November 1, 2011 merit decision that denied an additional 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 the case.

ISSUE

The issue is whether appellant has more than 13 percent impairment of the right arm or 4 percent impairment of the left arm for which he received schedule awards.

FACTUAL HISTORY

This case has previously been before the Board. In a September 24, 2009 decision, the Board found that appellant's claim that he sustained an injury when he fell while delivering mail

[1] 5 U.S.C. §§ 8101-8193.

on September 17, 2007 not in posture for decision. The Board remanded the case to OWCP for development of the medical evidence.[2] The facts of the previous Board decision are incorporated herein by reference.

On November 16, 2009 OWCP accepted that appellant sustained traumatic bursitis of the left elbow when he fell on September 17, 2007. Appellant filed a schedule award claim on November 20, 2009. By letter dated November 30, 2009, OWCP advised him to provide a physician's rating of impairment in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*).[3]

In a February 24, 2010 decision, OWCP denied appellant's claim for a schedule award on the grounds that he did not provide the requested medical evidence.

On October 27, 2008 OWCP accepted appellant's claim for right carpal tunnel syndrome.[4] On December 5, 2008 appellant filed a schedule award claim. On December 18, 2008 he asserted that he also had carpal tunnel syndrome on the left. On January 9, 2009 Dr. Rodger C. Dickinson, Jr., a Board-certified orthopedic surgeon, performed a right carpal tunnel release. On January 22, 2009 OWCP accepted left carpal tunnel syndrome and bilateral epicondylitis. On January 23, 2009 Dr. Dickinson performed a carpal tunnel release on the left.

On August 20, 2009 OWCP referred appellant to Dr. Alice M. Martinson, Board-certified in orthopedic surgery, for physical examination and an impairment evaluation. In an October 5, 2009 report, Dr. Martinson performed a physical examination and diagnosed status post bilateral carpal tunnel releases, osteoarthritis of the right elbow and mild lateral epicondylitis of the left elbow. She advised that she had evaluated appellant's impairment in accordance with the sixth edition of the A.M.A., *Guides* and completed an impairment worksheet. Dr. Martinson advised that, under Table 15-23, Entrapment/Compression Neuropathy Impairment, appellant had a class 1 impairment with a clinical studies modifier of 1, a functional history modifier of 2, and a physical examination modifier of 2, concluding that he had four percent impairment due to carpal tunnel syndrome on the right and on the left. Regarding appellant's post-traumatic degenerative joint disease, she advised that, under Table 15-4, Elbow Regional Grid, appellant had a class 1 impairment with modifiers for functional history, physical examination and clinical studies of 2 each, yielding an 11 percent right upper extremity impairment. Dr. Martinson further diagnosed a history of painful injury under Table 15-4, for a class 0 impairment, with modifiers for functional history, physical examination and clinical studies of 1, yielding no impairment. She added the right upper extremity impairments of 4 percent for carpal tunnel syndrome and 11 percent impairment for post-traumatic degenerative joint disease, yielding a total right upper extremity impairment of 15 percent.

In a November 5, 2009 report, Dr. Daniel D. Zimmerman, an OWCP medical adviser Board-certified in internal medicine, reviewed the medical record. He agreed that appellant had

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[2] Docket No. 09-259 (issued September 24, 2009). This case was adjudicated by OWCP under file number xxxxxx847.

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

[4] The 2008 claim was adjudicated by OWCP under file number xxxxxx920.

four percent impairments bilaterally due to carpal tunnel syndrome. Dr. Zimmerman noted that osteoarthritis of the right elbow had not been accepted as employment related and therefore Dr. Martinson's finding under Table 15-4, Elbow Regional Grid, was not acceptable. OWCP's medical adviser rated appellant's right epicondylitis as class 1, E, for a maximum two percent impairment. He concluded that she had six percent right upper extremity impairment and four percent left upper extremity impairment.

On February 4, 2010 appellant was granted schedule awards for four percent impairment of the left arm and six percent impairment of the right arm.

In treatment notes dated March 31 to July 19, 2010, Dr. Wesley K. Cox, a Board-certified orthopedist, described appellant's condition and treatment. He diagnosed bilateral elbow degenerative joint disease, advanced on the right; right elbow epicondylitis, a loose body in the left elbow and bilateral forearm pain. On September 28, 2010 Dr. Cox performed an excision of soft tissue mass of the left posterior elbow and right elbow intra-articular injection. He submitted reports describing appellant's postoperative care. A January 24, 2011 electrodiagnostic study of the upper extremities was consistent with moderate right ulnar neuropathy at the elbow and mild right median neuropathy at the wrist.

On March 14, 2011 OWCP accepted a permanent aggravation of osteoarthritis to the right elbow. On March 24, 2011 it doubled appellant's xxxxxx847 and xxxxxx920 claims. On April 4, 2011 Dr. Cox provided physical examination findings and diagnosed degenerative joint disease and cubital tunnel syndrome of the right elbow, bilateral carpal tunnel syndrome and bilateral/lateral epicondylitis.

In an April 13, 2011 report, Dr. Ronnie D. Shade, a Board-certified orthopedic surgeon, noted the accepted conditions, appellant's medical history and complaints. He diagnosed bilateral carpal tunnel syndrome, surgically treated; bilateral/lateral epicondylitis of the elbows; osteoarthritis of the right elbow and synovitis of the right elbow. Dr. Shade advised that maximum medical improvement was reached on April 13, 2011 and performed an impairment evaluation in accordance with the sixth edition of the A.M.A., *Guides*. Regarding carpal tunnel syndrome, he found that, under Table 15-23, appellant had class 1 impairment with a grade modifier of 1 for test findings, a modifier of 2 for history, and a modifier of 1 for physical findings, concluding that appellant had a three percent bilateral upper extremity impairment due to carpal tunnel syndrome. Regarding appellant's elbow condition, under Table 15-4, Dr. Shade identified a class 1 impairment due to left lateral epicondylitis, found modifiers of 1 for clinical studies, physical examination, and functional history and applied the net adjustment formula, for one percent left upper extremity impairment due to his elbow condition. On the right, he found a class 1 impairment due to post-traumatic degenerative joint disease. Dr. Shade found modifiers of 2 for functional history and physical examination, and applied the net adjustment formula, for nine percent right upper extremity impairment. He then added each elbow and wrist impairment, concluding that appellant had 12 percent right upper extremity impairment and 4 percent impairment on the left.

Appellant filed a claim for an additional schedule award on July 5, 2011. OWCP forwarded the record to Dr. Zimmerman for review. In a July 17, 2011 report, Dr. Zimmerman found that maximum medical improvement was reached on October 5, 2009, the date of

Dr. Martinson's report. He advised that appellant would be entitled to an increased award on the right, based on her opinion but noted that a class D impairment for post-traumatic degenerative joint disease under Table 15-4 yielded 7 percent impairment, not 11 percent identified by Dr. Martinson. Dr. Zimmerman noted that on November 5, 2009 he agreed that appellant had four percent impairments bilaterally due to carpal tunnel syndrome. Regarding the right upper extremity, OWCP's medical adviser combined the 4 percent impairment due to carpal tunnel syndrome and the 7 percent impairment due to degenerative joint disease, for a total of 11 percent right upper extremity impairment. Since appellant had previously received a rating of six percent right arm impairment, he had an additional seven percent impairment. OWCP's medical adviser reiterated this conclusion in an August 1, 2011 report.

By decision dated August 15, 2011, appellant was granted a schedule award for an additional seven percent impairment of the right upper extremity.

On September 8, 2011 appellant requested reconsideration. He asserted that OWCP's medical adviser did not consider Dr. Shade's evaluation or the diagnosis bilateral epicondylitis. Appellant submitted an impairment evaluation dated June 16, 2011 in which Jon Lee, a physical therapist, advised that appellant had 13 percent right upper extremity impairment and 4 percent left upper extremity impairment.

In a September 25, 2011 report, Dr. Zimmerman, OWCP's medical adviser, noted that the report from the physical therapist did not comport with the A.M.A., *Guides* which indicates that the impairment rating must be performed by a physician. He advised that he had reviewed Dr. Shade's report, noting that he found three percent bilateral impairment due to carpal tunnel syndrome. OWCP's medical adviser stated that, as Dr. Shade did not explain his elbow ratings, these could not be accepted. Therefore, there was insufficient medical evidence to establish that appellant was entitled to an additional schedule award.

In a merit decision dated November 1, 2011, OWCP denied modification of the August 15, 2011 decision, finding that the medical evidence did not establish any greater permanent impairment.

LEGAL PRECEDENT

The schedule award provision of FECA, and its implementing federal regulations,[5] 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. 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[6] For decisions after

[5] 20 C.F.R. § 10.404.

[6] *Id.* at § 10.404(a).

February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[7] For decisions issued after May 1, 2009, the sixth edition will be used.[8]

The sixth edition of 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).[9] 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).[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11]

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

ANALYSIS

The Board finds that appellant has not established that he has more than 13 percent impairment of the right arm and 4 percent impairment of the left arm. The accepted conditions are traumatic bursitis of the left elbow, bilateral carpal tunnel syndrome, bilateral epicondylitis and aggravation of osteoarthritis of the right elbow. On February 4, 2010 appellant was granted a schedule award for a right upper extremity impairment of six percent and a left upper extremity impairment of four percent. On August 15, 2011 he was granted a schedule award for an

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[7] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

[8] FECA Bulletin No. 09-03 (issued March 15, 2009).

[9] A.M.A., *Guides, supra* note 3 at 3, 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.

[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(d) (August 2002).

additional 7 percent on the right, for a total right upper extremity impairment of 13 percent. The record does not support entitlement to an additional award.

Regarding the left arm, Drs. Martinson and Zimmerman both found that appellant had four percent impairment due to carpal tunnel syndrome. Dr. Shade found three percent impairment due to carpal tunnel syndrome. The evidence does not establish greater impairment.

Regarding the right arm, the relevant medical evidence includes an October 5, 2009 report from Dr. Martinson, an OWCP referral physician, who noted that appellant had bilateral 4 percent impairments due to carpal tunnel syndrome and an additional 11 percent impairment on the right due to post-traumatic degenerative joint disease. As noted by Dr. Zimmerman on July 17, 2011, Dr. Martinson's finding regarding the right elbow under Table 15-4, Elbow Regional Grid, was not acceptable. Table 15-4 provides that the maximum allowed for post-traumatic degenerative joint disease of the elbow is nine percent.[15] When the 4 percent impairment for carpal tunnel syndrome is added to the maximum allowed for post-traumatic degenerative joint disease of the elbow, or 9 percent, a total of 13 percent is found. Appellant had previously received a schedule award for two percent impairment for right lateral epicondylitis on February 4, 2010. Section 15.2a of the A.M.A., *Guides* provides that, if more than one diagnosis is identified for each region, the diagnosis with the highest impairment rating should be used. Under Table 15-4, the maximum allowed for lateral epicondylitis is two percent,[16] whereas the maximum for degenerative joint disease is nine percent.[17] Appellant would therefore be best rated under the latter diagnosis. As he had previously received a right upper extremity impairment of two percent for lateral epicondylitis, when this is subtracted from nine percent, the maximum allowed for degenerative joint disease of the elbow, he was entitled to an additional seven percent right upper extremity impairment, which he was awarded on August 15, 2011.

Dr. Shade, an attending orthopedic surgeon, provided an April 13, 2011 impairment evaluation. He concluded that appellant had 4 percent total impairment on the left and 12 percent impairment on the right, less than the awards appellant received. Dr. Shade's report therefore does not establish entitlement to an increased award for either upper extremity.

The impairment evaluation dated June 16, 2011, completed by Mr. Lee, a physical therapist, does not constitute competent medical evidence as lay individuals such as physician's assistants, nurses and physical therapists are not competent to render a medical opinion under FECA.[18]

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[15] A.M.A., *Guides, supra* note 3 at 400.

[16] *Id*. at 399.

[17] *Id*. at 400.

[18] *David P. Sawchuk*, 57 ECAB 316 (2006). Section 8101(2) of FECA defines the term "physician" to include surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by state law. 5 U.S.C. § 8101(2). The Board also notes that Mr. Lee indicated that appellant had 13 percent right arm impairment and 4 percent impairment on the left, the exact awards appellant has received.

The Board finds that the record supports that appellant has no more than 13 percent right upper extremity impairment and 4 percent impairment on the left, for which he received schedule awards. There is no other medical evidence of record addressing the extent of his permanent impairment under the sixth edition of the A.M.A., *Guides*, which supports any greater impairment. Appellant is therefore not entitled to an increased award.

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 no more than 13 percent right upper extremity impairment and 4 percent impairment on the left.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated November 1 and August 15, 2011 be affirmed.

Issued: June 19, 2012
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

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

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