United States Department of Labor
Employees' Compensation Appeals Board

S.P., Appellant	)	
and	)	**Docket No. 11-1604**
	)	**Issued: March 8, 2012**
DEPARTMENT OF AGRICULTURE, FOOD & NUTRITION SERVICE, Dallas, TX, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On June 28, 2011 appellant filed a timely appeal from a May 17, 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 merits of the case.

ISSUE

The issue is whether appellant has more than 12 percent left upper extremity and 27 percent right upper extremity impairments.

FACTUAL HISTORY

On October 3, 2001 appellant, then a 42-year-old program technician, filed a Form CA-2, occupational disease, alleging that she developed bilateral wrist pain, numbness and tingling due to repetitive typing duties. OWCP accepted her claim for bilateral ulnar neuritis, bilateral

[1] 5 U.S.C. §§ 8101-8193.

brachial neuritis, bilateral sprain of the wrists and bilateral lesion of the ulnar nerve. Appellant did not stop work.[2]

Appellant was treated by Dr. Kenneth Driggs, a Board-certified orthopedic surgeon, from August 21, 2001 to September 4, 2002. Dr. Driggs noted that an electromyogram (EMG) dated October 18, 2001 revealed mild bilateral ulnar sensory neuropathy. On January 30, 2002 he performed a right Guyon canal ulnar nerve release with carpal tunnel release. On September 4, 2002 Dr. Driggs performed a right middle finger tendon sheath release and diagnosed flexor tenosynovitis of the right middle finger.

Appellant filed a claim for a schedule award. In a report dated July 9, 2003, an OWCP medical adviser found that she had a 20 percent impairment of the right arm due to motor deficits.

In a decision dated August 12, 2003, OWCP granted appellant a schedule award for five percent impairment of the right arm. In a decision dated August 27, 2003, it granted her a schedule award for 15 percent impairment of the right arm.

Appellant came under the treatment of Dr. Robert Ippolito, a Board-certified orthopedic surgeon, for significant pain and loss of strength in both hands and wrists. Dr. Ippolito diagnosed status post bilateral carpal tunnel decompression, flexor and extensor tendinitis, tenosynovitis bilaterally and left wrist triangular fibrocartilage complex (TFCC) tear. He recommended surgery. On May 25, 2005 Dr. Ippolito performed a debridement and open repair of the TFCC tear of the left wrist and diagnosed fibrocartilage complex tear.

On September 14, 2005 appellant filed a claim for a schedule award. In a November 28, 2005 decision, OWCP granted her a schedule award for 12 percent impairment of the left arm.

Appellant was treated by Dr. Olayinka Ogunro, a Board-certified orthopedic surgeon, from June 18, 2007 to June 19, 2008, for stiffness and numbness of the right fingers. Dr. Ogunro noted that her history was significant for right carpal tunnel release in 2001 and trigger finger release in 2001. He found diminished sensation to light touch over the ulnar distribution and tenderness over the distal ulnar. Dr. Ogunro diagnosed TFCC tear of the right wrist and cubital tunnel syndrome of the right elbow associated with continuous keyboarding at work. On November 30, 2007 he performed arthroscopic debridement of the right scapholunate ligament, intramuscular transposition of the ulnar nerve and z-lengthening of the flexor pronator group of muscles. In a February 21, 2008 report, Dr. Ogunro found that appellant had 12 percent impairment of the right arm under the A.M.A., *Guides.* He noted that she had five percent impairment for lost range of motion of the left wrist but noted range of motion figures for the right wrist. Dr. Ogunro further noted that 7 percent impairment for the left ulnar nerve combined with 5 percent impairment for the left wrist a 12 percent right upper extremity impairment.

[2] Appellant filed a claim for a back injury sustained on April 8, 1999 which was accepted by OWCP for lumbar sprain and lumbar surgery was authorized, claim number xxxxxx033.

In a May 8, 2008 report, an OWCP medical adviser noted that Dr. Ogunro provided range of motion figures for the right wrist but concluded that appellant had five percent impairment of the left wrist. The medical adviser requested that he clarify his impairment ratings.

In a May 25, 2008 report, Dr. Ogunro advised that appellant had seven percent impairment of the right arm. He noted findings for the right wrist range of motion and indicated that the left arm impairment was five percent. Dr. Ogunro further noted that appellant had a two percent impairment for the left ulnar nerve and combined the two percent impairment for the left ulnar nerve with five percent for the left wrist for seven percent right arm impairment.

In a May 8, 2008 report, an OWCP medical adviser noted that appellant previously received a 20 percent impairment rating of the right upper extremity based on motor and sensory deficits of the ulnar nerve. He found that she did not have any additional impairment of the right arm.

In a July 7, 2008 decision, OWCP denied appellant's claim for an additional schedule award.

On July 14, 2008 appellant requested a review of the written record. In a decision dated November 17, 2008, an OWCP hearing representative affirmed the July 7, 2008 decision.

Appellant submitted a November 11, 2008 magnetic resonance imaging (MRI) scan of the left wrist, which revealed laxity in the course of the ulnar collateral ligament, marrow edema throughout the triquetrum, mild tenosynovitis of the extensor carpal radialis longus and brevis tendons, increases signal of the dorsal aspect of the radioulnar ligaments suggestive of strains and/or partial thickness tear and mild fluid in all three compartments of the wrist. An EMG dated April 2, 2009 revealed mild bilateral carpal tunnel syndrome and mild ulnar neuropathy across the wrist. Appellant was treated by Dr. Ogunro from November 24, 2008 to August 18, 2010, for swelling and pain in the right hand and elbow radiating into the fingers. Dr. Ogunro diagnosed TFCC tear, status post repair with persistent pain with function. On August 18, 2010 he performed an excision of the first dorsal extensor retinaculum and synovectomy and diagnosed de Quervain's disease of the left wrist.

On January 31, 2011 appellant filed a claim for an additional schedule award. In a March 18, 2011 report, Dr. Ogunro noted that she was status post cubital tunnel release of the right elbow, TFCC tear and debridement of the right wrist performed on November 30, 2007 and status post de Quervain's release of the left wrist performed on August 18, 2010. He noted examination of the left wrist revealed sensitivity over the incision site, flexion of 50 degrees, extension of 60 degrees, ulnar deviation of 30 degrees and radial deviation of 20 degrees. With regard to the right elbow, Dr. Ogunro noted diminished sensation to light touch with the ulnar distribution and tenderness over the distal ulnar carpal joints. He noted an MRI scan of the right wrist revealed degeneration of the ulnar attachment of the TFCC ligament. Dr. Ogunro diagnosed de Quervain's disease, left wrist, status post release, tendinitis of the left elbow and shoulder, ganglion of the right middle finger, resolved trigger finger of the right index finger, status post arthroscopic TFCC ligament debridement of the right wrist, status post cubital tunnel release of the right elbow. He evaluated appellant's left wrist condition under Table 15-3 (Wrist Regional Grid) on pages 395-97. Dr. Ogunro found that she met the criteria for left wrist

sprain/strain, de Quervain's disease, with a history of painful injury, residual symptoms without consistent objective findings, fell under class 1 with a default value of one percent impairment. Under functional history adjustment, he found a grade modifier of 1 for pain/symptoms with strenuous/vigorous activity under Table 15-7, page 406. Under physical examination adjustment, Dr. Ogunro found that appellant had a grade modifier of 1 under Table 15-8, page 408 for mild problems, with regard to clinical studies he noted that it was not applicable. He applied the net adjustment formula under page 411. Dr. Ogunro found that Functional History (GMFH - CDX) + Physical Examination (GMPE - CDX) equaled (1-1) + (1-1) which equaled zero. As there was no net adjustment, he opined that appellant had one percent left arm impairment.

As to the right TFCC tear, Dr. Ogunro evaluated appellant under Table 15-3. He noted that she was status post TFCC ligament debridement of the right wrist, with residual findings and fell under class 1 with a default value of eight percent. Under functional history adjustment, Dr. Ogunro found a grade modifier of 1 for pain/symptoms with strenuous/vigorous activity under Table 15-7, page 406. Under physical examination adjustment, he found that appellant was a grade modifier of 2, under Table 15-8, page 408, for moderate problems, for clicking and clunking reproducible on physical examination. Under clinical studies adjustment, Dr. Ogunro found that she was a grade modifier 1, Table 15-9, page 410, which confirmed diagnosis and mild pathology. He applied the net adjustment formula under page 411 and found (GMFH – CDX) + (GMPE – CDX) + Clinical Studies (GMCS – CDX) equaled (1-1) + (2-1) + (1-1) which equaled a net adjustment of 1. Dr. Ogunro noted that the default value (grade C) for TFCC tear under Table 15-3, page 395 was eight percent impairment and since the net adjustment was one, this totaled nine percent impairment.

Dr. Ogunro evaluated appellant's cubital tunnel of the right elbow under Table 15-23 (Entrapment/Compression Neuropathy Impairment) on page 449. He noted that the diagnosed cubital tunnel syndrome was confirmed electrodiagnostically and she was at maximum medical improvement. Under testing findings, appellant was a grade modifier 1 (conduction delay), history was a grade modifier 2 (significant intermittent symptoms) and physical findings were a grade modifier 2 (decreased sensation). Dr. Ogunro found that the grade modifier total was 5 (1+2+1) an average of 1.66. He noted a grade modifier of 2 was selected with a default of five percent. Dr. Ogunro noted that the *Quick*DASH was 43, moderate, therefore, the default for the grade modifier was selected. He concluded that appellant had impairment of one percent of the left arm for de Quervain's disease and 14 percent combined right arm impairment. Dr. Ogunro indicated that her other diagnoses did not warrant an impairment rating.

In an April 27, 2011 report, an OWCP medical adviser reviewed the medical evidence and found that appellant reached maximum medical improvement on March 18, 2011, the date of Dr. Ogunro's evaluation. Dr. Ogunro rated one percent permanent impairment of the left arm for de Quervain's tenosynovitis under the A.M.A., *Guides*. The medical adviser essentially agreed but noted that appellant already received 12 percent impairment for the left arm based on loss of wrist motion. Since the current determination was based on the same anatomic structure (wrist) that amount would be subtracted from the rating amount previously accepted which resulted in no additional left arm impairment. With regard to the diagnosed compression neuropathy, ulnar nerve (cubital tunnel syndrome), the medical adviser found that appellant had five percent permanent impairment of the right arm under the A.M.A., *Guides*. He agreed with Dr. Ogunro's

use of Table 15-23 of the A.M.A., *Guides* and his selection of grade modifiers which yielded a finding of five percent right arm impairment. The medical adviser noted that OWCP previously accepted 20 percent permanent impairment for the right arm based on loss of ulnar nerve function and opined that amount should be subtracted from the current ulnar nerve findings of 5 percent which would result in no additional impairment based on the ulnar nerve. With regard to the diagnosed right wrist TFCC tear, the medical adviser found that appellant had nine percent permanent impairment of the right arm under the A.M.A., *Guides*. The medical adviser agreed with Dr. Ogunro's use of Table 15-3 of the A.M.A., *Guides*, which provided for a default impairment of eight percent. He concurred in Dr. Ogunro's application of grade modifiers which yielded a net adjustment of one, which shifted the impairment to nine percent of the right arm. The medical adviser explained that the current finding of 9 percent impairment of the right arm for the TFCC tear would be combined with the previously awarded 20 percent, which yielded 27 percent, from which the prior award of 20 percent was subtracted.

In a decision dated May 17, 2011, OWCP granted appellant a schedule award for an additional seven percent impairment of the right upper extremity. The period of the award was March 18 to August 17, 2011.

LEGAL PRECEDENT

The schedule award provision of FECA[3] and its implementing federal regulations,[4] 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.[5] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[6]

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).[7] Under the sixth edition, for lower extremity impairments the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.[8] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[9]

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] *Id.* at § 10.404(a).

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

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

[8] *Id.* at 494-531.

[9] *Id.* at 521.

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides* with the medical adviser providing rationale for the percentage of impairment specified.[10]

OWCP procedures state that any previous impairment to the member under consideration is included in calculating the percentage of loss, except when the prior impairment is due to a previous work-related injury, in which case the percentage already paid is subtracted from the total percentage of impairment.[11]

ANALYSIS

OWCP accepted appellant's claim for bilateral ulnar neuritis, bilateral brachial neuritis, bilateral sprain of the wrists and bilateral lesion of the ulnar nerve. On May 17, 2011 it granted her an additional schedule award for seven percent impairment of the right arm. OWCP had previously issued schedule awards totaling 20 percent for the right arm and 12 percent for the left arm.

In a March 18, 2011 report, Dr. Ogunro found that appellant had one percent permanent impairment of the left arm for de Quervain's tenosynovitis under the A.M.A., *Guides*. As noted, pursuant to Table 15-3 of the A.M.A., *Guides*, appellant was a class 1 rating for mild problem with a default value of one percent and, applying grade modifiers, there was no net adjustment of the default one percent value. For the diagnosed right TFCC tear, Dr. Ogunro found that she had nine percent impairment of the right arm under Table 15-3 of the A.M.A., *Guides*, which provides a default value of eight percent impairment for a class 1 mild problem. He applied grade modifiers to the net adjustment formula for a net adjustment of one, which resulted in nine percent impairment of the right arm. For the diagnosed compression neuropathy, ulnar nerve (cubital tunnel syndrome), Dr. Ogunro found that appellant had five percent permanent impairment of the right arm under the A.M.A., *Guides*. Pursuant to Table 15-23 of the A.M.A., *Guides*, he noted grade modifiers and selected grade modifier 2 in Table 15-23 with a default of five percent which he opined was applicable based on appellant's moderate *Quick*DASH score. Dr. Ogunro concluded that she was entitled to an additional 1 percent impairment of the left arm and 14 percent impairment of the right arm.

OWCP medical adviser reviewed Dr. Ogunro's report and concurred in his impairment calculations. However, the medical adviser properly indicated that appellant was previously granted 12 percent impairment of the left arm based on loss of wrist motion for the same anatomic structure (wrist) she was not entitled to an additional award for de Quervain's tenosynovitis since the current finding, 1 percent, was less than the previously accepted amount, 12 percent. FECA provides for reduction of compensation for subsequent injury to the same body member. It provides that schedule award compensation under section 8107 is reduced by the compensation paid for an earlier injury where the compensation in both cases are for

[10] *See Federal* (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

[11] *Id*. at Chapter 2.808.7.a(2) (November 1998).

impairment of the same member or function and where it is determined that the compensation for the later disability in whole or part would duplicate the compensation payable for the preexisting disability.[12] OWCP procedures provide that if prior impairment to an area is due to a previous work-related injury the percentage already paid is subtracted from the total percentage of impairment.[13] Likewise, for the diagnosed compression neuropathy, ulnar nerve (cubital tunnel syndrome), the medical adviser noted that appellant previously received a 20 percent right arm schedule award based on loss of ulnar nerve function and that amount should be subtracted from the current ulnar nerve findings, 5 percent subtracted from 20 percent yields no additional impairment based on the ulnar nerve.

With regard to the diagnosed TFCC tear, an OWCP medical adviser concurred with Dr. Ogunro's determination that appellant had nine percent permanent impairment of the right arm under the A.M.A., *Guides*. He did not indicate that impairment due to the TFCC tear would duplicate prior accepted impairment. The medical adviser combined the 9 percent impairment of the right upper extremity for the TFCC tear with the previous accepted right arm impairment of 20 percent which resulted in 27 percent total impairment.[14] He then subtracted the previously awarded 20 percent impairment from 27 percent to arrive at 7 percent additional impairment which is what OWCP properly awarded appellant.

The Board finds that the medical evidence establishes that appellant sustained no more than a 27 percent impairment of the right upper extremity and 12 percent impairment of the left upper extremity.

On appeal, appellant asserts that OWCP failed to consider all her conditions of her left arm conditions in rating impairment. She questioned why there was no rating for her desensitization in the left hand and wrist, left wrist ganglion cyst and left elbow tendinitis. However, Dr. Ogunro noted appellant's various conditions and provided ratings for conditions that he determined to be ratable. He specifically found that certain conditions, such as left elbow tendinitis, were not ratable. Appellant provided no other current medical evidence, in conformance with the A.M.A., *Guides*, which supports any greater impairment.

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 12 percent impairment of the left upper extremity and 27 percent impairment of the right upper extremity.

[12] 5 U.S.C. § 8108; 20 C.F.R. § 10.404(c).

[13] *Supra* note 11.

[14] *See* A.M.A., *Guides*, 604 (Combined Values Chart).

ORDER

IT IS HEREBY ORDERED THAT the May 17, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 8, 2012
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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