United States Department of Labor
Employees' Compensation Appeals Board

V.T., Appellant	)	
and	)	**Docket No. 12-334**
	)	**Issued: October 26, 2012**
U.S. POSTAL SERVICE, POST OFFICE, Reston, VA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On December 5, 2011 appellant filed a timely appeal from an August 4, 2011 decision of the Office of Workers' Compensation Programs (OWCP) which denied his request for 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, which denied merit review.

ISSUE

The issue is whether appellant has more than 29 percent permanent impairment of the right upper extremity for which he received a schedule award.

FACTUAL HISTORY

On March 11, 2002 appellant, a 58-year-old letter carrier, filed a claim alleging that on the same day while placing two tubs of flats on the floor his fingers got caught between the tubs

[1] 5 U.S.C. §§ 8101-8193.

and he sustained a ruptured tendon in his pinkie and ring finger. OWCP accepted his claim for ruptured tendon of the right hand and authorized surgery. Appellant retired on February 28, 2011.

Appellant was treated by Dr. Swati Shirali, a Board-certified orthopedist, from March 11, 2002 to May 30, 2003, for a right wrist tendon rupture to the small finger. On March 28, 2002 Dr. Shirali performed an exploration with partial synovectomy and tenodesis of the tendon of the small finger to the tendon of the right finger. He diagnosed right hand flexor digitorum superficialis (FDS) and flexor digitorum profundus (FDP) tendon ruptures. On August 7, 2002 Dr. Shirali performed a lumbrical release with exploration and excision of the lumbrical and re-tensioning of the small finger FDS to the ring finger FDP tendinosis. He diagnosed incomplete flexion, small finger with paradoxical extension and status post right small finger FDP tenodesis to the right finger FDS tendon. Appellant was treated by Dr. Thomas A. Bruce, a Board-certified family practitioner, from September 23, 2003 to October 28, 2004, for the March 11, 2002 right hand injury. Dr. Bruce diagnosed ruptured tendons to the right fourth and fifth fingers. In an April 23, 2004 duty status report, he diagnosed repair of the ruptured right tendon of the fourth and fifth fingers and returned appellant to work with restrictions. In an October 28, 2004 attending physician's report, Dr. Bruce diagnosed right hand small finger FDS and FDP tendon ruptures. On October 5, 2004 appellant filed a claim for a schedule award.

In a decision dated June 23, 2005, OWCP granted appellant a schedule award for 29 percent impairment of the right upper extremity.

Thereafter, appellant continued to submit medical evidence. Reports from Dr. J. Mark Evans, a Board-certified orthopedist, dated June 23 to October 1, 2009, diagnosed possible ulnar neuropathy of the right upper extremity. In an October 1, 2009 report, Dr. Evans noted that appellant was at maximum medical improvement. He provided an impairment rating under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment.*[2] Using Table 15-3 on page 395, Dr. Evans noted that appellant sustained a wrist laceration and ruptured muscular tendon, which was class 1 with a default impairment value of five percent of the arm using the wrist regional grid. Using Table 15-7 on page 406, appellant had a functional history grade modifier 2 based on his ability to perform self-care activities with modification but unassisted. Using Table 15-8 on page 408, he had a grade modifier of 2 due to decreased range of motion at the proximal interphalangeal (PIP) joints of the small and ring fingers. Using Table 15-9 on page 410, appellant had clinical studies grade modifier of 1 based on his electromyogram/nerve conduction velocity (EMG/NCV) study. His net adjustment formula was +2, which correlated with seven percent arm impairment using Table 15-3 on page 395. Dr. Evans also provided an impairment rating for carpal tunnel syndrome. Using Table 15-23 on page 449, under entrapment/compression neuropathy impairment, appellant was judged to be a grade 1 modifier due to a conduction delay preoperatively as well as a history with mild intermittent symptoms. Dr. Evans noted decreased sensation in a nondermatoma distribution, specifically decreased sensibility at all the fingertips and not only the median nerve fingertips. This was in light of the fact that the EMG/NCV study revealed no evidence of ulnar neuropathy. Dr. Evans found this to be not reproducible, and as such, his physical findings were judged

[2] A.M.A., *Guides* (6th ed. 2009).

normal as appellant had no thenar atrophy. Appellant's functional scale was felt to be mild with respect to his carpal tunnel syndrome. Therefore, he had two percent impairment of the upper extremity for carpal tunnel syndrome. Using the Combined Values Chart, appellant had a seven percent impairment of the arm for his tendon ruptures combined with two percent impairment for his carpal tunnel syndrome for a nine percent impairment of the upper extremity. He submitted an EMG dated September 15, 2009, which revealed right median neuropathy at the wrist, carpal tunnel syndrome.

On April 13, 2010 appellant filed a claim for an additional schedule award.

OWCP referred appellant's case record to a medical adviser who opined that appellant had five percent impairment of the right arm. The medical adviser indicated that Dr. Evans used the wrist grid to determine impairment; however, a more applicable approach was to use the diagnosis-based impairment for the digit. He noted Table 15-2, Digit Regional Grid, ligament/bone/joint, for the diagnoses of flexor tendon rupture/laceration, appellant was a class 1 rating for residual loss, symptoms, functional with normal motion, with a default impairment of six percent for the digit. Under Table 15-7, Functional History Adjustment: Upper Extremities, appellant was assigned a grade modifier 2, consistent with pain/symptoms with normal activity and medications to control the symptoms. In Table 15-8, Physical Examination Adjustment, appellant was assigned a grade modifier 2, as the physical examination revealed moderate motion deficits. With regard to clinical studies, Table 15-9, appellant was assigned a grade modifier of zero as there were no findings with regard to this diagnosis. In summary, the medical adviser noted the functional history grade modifier of 2, physical examination of 2 and clinical studies of zero for a net adjustment of +1 which correlated to a grade D, seven percent impairment for each right and little finger. Table 15-12 provides that the digit impairment converts to one percent hand impairment, for a total impairment for both digits of two percent of the hand.

The medical adviser noted that alternatively the range of motion method may be used to evaluate impairment to the digits. He noted permanent impairment was calculated through the use of section 15-7, finger motion, for the distal interphalangeal (DIP) joint, PIP joint and metacarpophalangeal (MCP) joint. The medical adviser noted that for range of motion impairments the section was used as a stand-alone rating and cannot be combined with the diagnosis-based impairment method. Using Table 15-31, Finger Range of Motion, the PIP measurement for flexion was 100 degrees for 0 impairment and for extension was -20 degrees for 14 percent impairment to the digit. The 14 percent digit impairment converts to 1 percent hand impairment for the right ring finger pursuant to Table 15-12, page 421-22. With regard to the little finger, using Table 15-31, the PIP measurement for flexion was 48 degrees for a 21 percent impairment to the digit and extension was 25 degrees for a 14 percent impairment to the digit for a total impairment of 35 percent to the digit. The 35 percent digit impairment converts to 4 percent impairment of the hand under Table 15-12. The final hand impairment was determined by adding the values together, for five percent hand impairment related to the range of motion loss of the right ring and small finger. The medical adviser noted that Dr. Evans provided a rating for carpal tunnel syndrome; however, appellant's claim was not accepted for carpal tunnel syndrome. He noted that the diagnosis-based impairment rating provided two percent arm impairment and the impairment for loss of range of motion provided five percent

arm impairment, neither can be combined. The medical adviser opined that the most applicable methodology was the five percent hand impairment based on range of motion impairment to the digits since this was the body part primarily impacted.

In a decision dated July 21, 2010, OWCP denied appellant's claim for an additional award. It advised that he was previously granted a schedule award for 29 percent impairment to the right upper extremity and was not entitled to an additional award.

In a statement dated August 12, 2010, appellant requested reconsideration and indicated that he could not see his physician until September 7, 2010. He submitted a duty status report from Dr. Bruce dated November 29, 2010 who noted appellant underwent a repair of the ruptured fourth and fifth tendon. Dr. Bruce noted clinical findings of tendon weakness and loss of range of motion. He returned appellant to work with restrictions. Also submitted was a limited-duty job offer dated August 24, 2010, for a modified city carrier.

By decision dated July 21, 2011, OWCP denied modification of the July 21, 2010 decision. On August 4, 2011 it reissued the July 21, 2011 decision to preserve appellant's appeal rights.

LEGAL PRECEDENT

The schedule award provision of FECA[3] and its implementing 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 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.[5]

For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[6] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[7] It is the claimant's burden to establish that he or she sustained a permanent impairment of a scheduled member or function as a result of an employment injury.[8]

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] *See id*.; *Jacqueline S. Harris*, 54 ECAB 139 (2002).

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

[7] A.M.A., *Guides* (6th ed. 2009).

[8] *Tammy L. Meehan*, 53 ECAB 229 (2001).

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 of the A.M.A., *Guides*, 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]

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 percentage of impairment using the A.M.A., *Guides*.[12]

ANALYSIS

Appellant's claim was accepted by OWCP for ruptured tendons of the right hand and authorized surgery which was performed on March 28 and August 7, 2002. On June 23, 2005 OWCP granted him a schedule award for 29 percent impairment of the right arm. On April 13, 2010 appellant claimed an increased schedule award. The Board finds that the medical evidence of record establishes no greater than 29 percent impairment to his right arm.

Appellant submitted an October 1, 2009 report from his treating physician, Dr. Evans, who opined that appellant had seven percent upper extremity under the sixth edition of the A.M.A., *Guides.*[13] He used the Wrist Grid on Table 15-3 on page 395 for a wrist laceration and ruptured muscular tendon. However, the Board notes that appellant sustained a crushing injury to his fingers and his condition was accepted for a ruptured tendon of the right hand. The evidence does not indicate that his injury extended beyond the fingers to the wrist. The Board further notes that Dr. Evans provided an impairment rating for carpal tunnel syndrome. However, OWCP did not accept appellant's claim for carpal tunnel syndrome and although preexisting impairments may be considered there is no evidence that carpal tunnel syndrome was a preexisting condition.[14] In any event, the total impairment found by Dr. Evans was substantially less than the 29 percent right arm impairment previously awarded by OWCP for appellant's condition. Therefore the Board finds that Dr. Evans provides no basis for payment of an increased schedule award.

[9] A.M.A., *Guides, supra* note 1 at 3, section 1.3, ICF: A Contemporary Model of Disablement.

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

[11] *Id.* at 411.

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

[13] A.M.A., *Guides* (6th ed. 2009).

[14] *See K.H.*, Docket No. 09-341 (issued December 30, 2009) (it is well established that, in determining the amount of a schedule award for a given member of the body that sustained an employment-related permanent impairment, preexisting impairments of that scheduled member of the body are to be included).

An OWCP medical adviser reviewed Dr. Evans findings and utilized the sixth edition of the A.M.A., *Guides* to find five percent impairment of the right arm. He noted that there were two rating methodologies that were appropriate under the A.M.A., *Guides*, diagnosis-based impairment or lost range of motion but only the greater of the two methods could be used. As explained, under the diagnosis-based impairment, Table 15-2, Digit Regional Grid, for the diagnosis of flexor tendon rupture/laceration, appellant had a default impairment of six percent for the digit. After applying grade modifiers and the net adjustment formula, which resulted in a modifier of +1, the medical adviser determined that appellant had seven percent impairment for each right and little finger. He explained how this converted to two percent of the hand.[15] The medical adviser noted that alternatively the range of motion method may be used to evaluate impairment to the digits. He noted that for range of motion impairments the section was used as a stand-alone rating and cannot be combined with the diagnosis-based impairment method. Using Table 15-31, Finger Range of Motion, the PIP measurement for flexion was 100 degrees for zero impairment and for extension was -20 degrees for 14 percent impairment to the digit. The 14 percent digit impairment converts to 1 percent hand impairment for the right ring finger pursuant to Table 15-12, page 421-22. With regard to the little finger, the PIP measurement for flexion was 48 degrees for 21 percent impairment to the digit and extension was 25 degrees for 14 percent impairment to the digit for total impairment of 35 percent impairment to the digit. The 35 percent digit impairment converts to a 4 percent impairment of the hand pursuant to Table 15-12. The final hand impairment was determined by adding the values together, for five percent hand impairment for lost range of motion. The medical adviser noted that, since the diagnosis-based impairment rating provided two percent hand impairment, the most applicable methodology was five percent hand impairment for lost range of motion. However, appellant was not entitled to an increased schedule award since he previously received a schedule award for 29 percent impairment of the right arm for the same injury.

The Board finds that the medical adviser properly applied the A.M.A., *Guides* (6th ed. 2008) to rate impairment to appellant's right arm as set forth by Dr. Evans. The weight of medical evidence establishes that appellant has no more than 29 percent permanent impairment of the right arm for which he previously received a schedule 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 OWCP properly denied appellant's claim for an additional schedule award.

[15] Table 15-12, A.M.A., *Guides* 402.

ORDER

IT IS HEREBY ORDERED THAT the August 4, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 26, 2012
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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