United States Department of Labor
Employees' Compensation Appeals Board

D.S., Appellant	)	
and	)	**Docket No. 12-869**
	)	**Issued: September 21, 2012**
U.S. POSTAL SERVICE, POST OFFICE, San Bernardino, CA, 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 March 13, 2012 appellant filed a timely appeal from a January 23, 2012 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 schedule award decision.

ISSUE

The issue is whether appellant established that she has more than a six percent impairment of the right upper extremity and a five percent impairment of the left upper extremity for which she received a schedule award.

FACTUAL HISTORY

On March 13, 1997 appellant, then a 47-year-old letter carrier, sustained an employment-related injury when she fell backward while being attacked by a dog. She also has accepted

[1] 5 U.S.C. §§ 8101-8193.

occupational disease claims. Under all claims, OWCP has accepted strain/sprain of the neck, bilateral shoulder and arm, thoracic and lumbar regions, acute reaction to stress, bilateral carpal tunnel syndrome, bilateral rotator cuff syndrome, right radial styloid tenosynovitis and other shoulder conditions.[2] Appellant underwent left and right carpal tunnel decompression procedures and left shoulder surgery. She retired on June 14, 2008.

In a September 4, 2008 decision, the Board found that OWCP met its burden of proof to establish that appellant's actual wages as a modified city carrier fairly and reasonably represented her wage-earning capacity and affirmed a June 7, 2007 OWCP decision.[3] The law and the facts of the previous Board decision are incorporated herein by reference.

On January 3, 2011 appellant filed a schedule award claim and submitted an August 7, 2009 report, in which Dr. William Simpson, an attending orthopedic surgeon, noted her complaints of neck, low back and bilateral upper extremity pain. Dr. Simpson provided physical examination findings and diagnosed chronic cervical musculoligamentous sprain with radiculopathy, chronic lumbosacral musculoligamentous sprain, chronic bilateral shoulder impingement syndromes, chronic bilateral carpal tunnel syndrome, chronic bilateral de Quervain's syndrome, chronic situational depression, anxiety, chronic insomnia and chronic gastrointestinal irritation. He summarized appellant's care and discussed subjective and objective disability factors. Dr. Simpson advised that she had reached maximum medical improvement and that, under Table 17-2 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[4] she had a class 4 impairment due to a 40 degree loss of cervical motion, for 30 percent impairment of the cervical spine. He found that, under Table 17-4, appellant had a class 4 impairment due to a 45 degree loss of lower back motion, for 35 percent impairment of the thoracolumbar spine. Regarding the upper extremities, Dr. Simpson found that, under Table 15-5, Table 15-7, Table 15-8 and Table 15-9, she had a class 3 or 25 percent impairment of the right and left shoulder and that under Table 15-3, a class 3 or 30 percent impairment of the right and left wrists. Regarding the shoulders and wrists, he stated that his impairment rating was based on "the adjustment grade, grade modifiers, functional history, physical examination and clinical tests."

In a September 26, 2011 report, Dr. Ronald Blum, an OWCP medical adviser who is a Board-certified orthopedic surgeon, noted his review of the medical record including Dr. Simpson's report. He advised that it was unclear how Dr. Simpson arrived at his impairment values since they did not seem to be in accordance with the A.M.A., *Guides*. Dr. Blum recommended an impairment evaluation by an OWCP referral physician.

OWCP referred appellant to Dr. John Sklar, a Board-certified physiatrist, for an impairment evaluation. In a December 2, 2011 report, which included a permanent impairment worksheet, Dr. Sklar noted his review of the statement of accepted facts and medical record. He reported appellant's complaint of chronic pain in the cervicothoracic region and arm and

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[2] OWCP claim numbers xxxxxx070, xxxxxx019 and xxxxxx119 have been combined.

[3] Docket No. 08-7 (issued September 4, 2008).

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

provided examination findings. Dr. Sklar advised that maximum medical improvement was reached on August 7, 2009, the date of Dr. Simpson's report and noted that appellant's chronic pain appeared to be myofascial in nature. He indicated that the widespread nature of the problem suggested a diagnosis of fibromyalgia and advised that he would rate appellant for bilateral carpal tunnel syndrome, bilateral rotator cuff syndrome and right radial styloid tenosynovitis only because she had no upper extremity physical findings such as radiculopathy to relate to the accepted cervical, thoracic and lumbar strains and sprains and, as such, those conditions were not ratable for the purposes of determining a schedule award. Dr. Sklar found that, under Table 15-5, Shoulder Regional Grid, for a diagnosis of bilateral impingement syndrome with some residual loss, appellant had a class 1 impairment, which had a default value of C for three percent impairment. He noted that, based on appellant's *Quick*DASH score of 70, she had a functional history modifier of three, but that, since this was 2 grades higher than the class 1 grade, the functional history adjustment was invalid. Dr. Sklar found that appellant had evidence of a mild problem on physical examination, which would place her in grade 1 and that she had a clinical studies modifier of zero, since there were no studies available. He applied the net adjustment formula, finding a minus one or grade of B, which yielded a bilateral two percent impairment due to shoulder impingement syndrome.

Dr. Sklar also provided a right upper extremity rating based on appellant's de Quervain's tendinitis using Table 15-3, Wrist Regional Grid. He found a class 1 impairment. Dr. Sklar again explained that a functional history modifier was invalid and found a grade 1 modifier for physical examination and no modifier for clinical studies. After applying the net adjustment formula, he concluded that appellant had one percent impairment due to de Quervain's disease.

Dr. Sklar additionally rated appellant's bilateral carpal tunnel syndrome under Table 15-23, Entrapment/Compression Neuropathy Impairment. He found a grade 1 modifier for conduction delay on testing, a grade 1 modifier for mild intermittent symptoms on history and a grade 1 modifier for a normal physical examination. This placed appellant in grade 1 with an impairment range of one to three percent. Due to her *Quick*DASH score of 70, Dr. Sklar found three percent upper extremity impairment bilaterally due to carpal tunnel syndrome. He concluded that appellant had six percent right arm impairment due to shoulder impairment syndrome, de Quervain's tendinitis and carpal tunnel syndrome and a five percent impairment on the left, due to shoulder impairment syndrome and carpal tunnel syndrome.

On January 3, 2012 Dr. Blum, an OWCP medical adviser, reviewed the statement of accepted facts and medical record, including Dr. Sklar's report. He agreed that maximum medical improvement had been reached on August 7, 2009. Regarding appellant's impairment rating, the medical adviser provided analysis under Table 15-5, Table 15-3 and Table 15-23. He applied appropriate modifiers and the net adjustment formula and agreed with Dr. Sklar's assessment that under Table 15-5 appellant had bilateral upper extremity impairments of two percent due to shoulder impairment syndrome that, under Table 15-3, she had one percent right arm impairment due to de Quervain's and that, under Table 15-23, she had a bilateral three percent impairment due to compression neuropathy of the median nerve, for a total impairment of six percent on the right and five percent on the left.

On January 23, 2012 appellant was granted a schedule award for six percent impairment of the right upper extremity and a five percent impairment of the left, for a total of 34.32 weeks, to run from August 7, 2009 to April 4, 2010.

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 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]

Although the A.M.A., *Guides* includes guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under FECA for injury to the spine.[12] In 1960, amendments to FECA modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. Therefore, as the schedule award provisions of FECA include the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[13]

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[5] 20 C.F.R. § 10.404.

[6] *Id*. at § 10.404(a).

[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 4 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] *Pamela J. Darling*, 49 ECAB 286 (1998).

[13] *Thomas J. Engelhart*, 50 ECAB 319 (1999).

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[14] In Table 15-23, grade modifier 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.[15]

OWCP's 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.[16]

ANALYSIS

The Board finds that appellant has not established that she has more than six percent impairment of the right arm and five percent impairment on the left, for which she received a schedule award on January 23, 2012. The accepted conditions are strain/sprain of the neck, bilateral shoulder and arm thoracic and lumbar regions; acute reaction to stress; bilateral carpal tunnel syndrome; bilateral rotator cuff syndrome; right radial styloid tenosynovitis; and other shoulder conditions. The Board finds that the weight of the medical evidence rests with the opinion of Dr. Sklar, OWCP's referral physician and Dr. Blum, the medical adviser, the only impairment evaluations of record that comport with the sixth edition of the A.M.A., *Guides*. The record does not support that appellant is entitled to an additional schedule award.

Regarding the diagnosed spine conditions, Dr. Simpson, an attending orthopedic surgeon, utilized Table 17-2, Cervical Spine Regional Grid and Table 17-4, Lumbar Spine Regional Grid and found impairments of 30 and 35 percent respectively due to loss of spine motion. As noted above, a schedule award is not payable for injury to the spine.[17] Dr. Sklar advised that he found no upper extremity impairment relative to the accepted spinal conditions based on his physical examination findings. Thus appellant would not be entitled to a schedule award for the cervical, thoracic and lumbar conditions.

The Board also finds that the arm impairments found by Dr. Simpson for bilateral shoulder impairment syndrome, right wrist de Quervain's and bilateral carpal tunnel syndrome are of diminished probative value, as he did not properly apply the A.M.A., *Guides*. Under the sixth edition of the A.M.A., *Guides*, for upper extremity impairments the evaluator is to first identify an impairment class for the diagnosed condition which is then adjusted by grade

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[14] A.M.A., *Guides, supra* note 4 at 449.

[15] *Id*. at 448-50.

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

[17] *Pamela J. Darling, supra* note 12.

modifiers based on functional history, physical examination and clinical studies.[18] The evaluator is to then apply the net adjustment formula.[19] Section 15.2a of the sixth edition provides that the first step in determining an impairment rating is to choose the diagnosis that is most applicable for the region being assessed, to be followed by assessment in accordance with Table 15-7 through Table 15-9.[20] Dr. Simpson merely stated that he had based his rating on "the adjustment grade, grade modifiers, functional history, physical examination and clinical tests," without providing a specific analysis under the appropriate tables or applying the net adjustment formula.

Regarding the bilateral shoulder condition, Dr. Sklar, OWCP's referral physician, provided impairment ratings in accordance with Table 15-5, Shoulder Regional Grid, which provides that impingement syndrome with residual loss is rated as class 1 which yields impairments ranging from zero to five percent.[21] He properly noted that section 15.3a of the A.M.A., *Guides* provides that if the grade for functional history differs by two or more grades from that described by physical examination or clinical studies, the functional history should be assumed unreliable and is to be excluded from the grading process.[22] Dr. Sklar then properly applied the net adjustment formula, finding a minus one or grade of B, which yielded a bilateral two percent impairment due to shoulder impingement syndrome.

For right wrist de Quervain's tendinitis, as found by Dr. Sklar, Table 15-3, Wrist Regional Grid, provides that a wrist sprain/strain or tendinitis with residual symptoms is a class 1 impairment with a default grade of C or one percent.[23] He found a physical examination modifier of one and a clinical studies modifier of zero. As noted, the functional history modifier was invalid. Thus, Dr. Sklar properly utilized Table 15-3, identified the proper grade modifiers and applied the net adjustment formula, in reaching his conclusion that appellant had a one percent right arm impairment due to de Quervain's tendinitis.

Regarding the bilateral carpal tunnel syndrome, impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23, Entrapment/Compression Neuropathy Impairment and accompanying relevant text.[24] In Table 15-23, grade modifiers are described for the categories test findings, history and physical findings which 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.[25] Dr. Sklar identified a modifier of one for

[18] A.M.A., *Guides, supra* note 4 at 385-419.

[19] *Id*. at 411.

[20] *Id*. at 389-90.

[21] *Id*. at 402.

[22] *Id*. at 406-07.

[23] *Id*. at 395.

[24] *Id*. at 449.

[25] *Id*. at 448-50.

conduction delay on testing, a modifier of one for mild intermittent symptoms on history and a modifier of one for a normal physical examination. This placed appellant in grade 1, which has an impairment range of one to three percent. Dr. Sklar found that appellant had three percent upper extremity impairment bilaterally due to carpal tunnel syndrome, based on her *Quick*DASH score of 70. He combined the impairment values and concluded that appellant had a six percent right arm impairment due to shoulder impairment syndrome, de Quervain's tendinitis and carpal tunnel syndrome and a five percent impairment on the left, due to shoulder impairment syndrome and carpal tunnel syndrome.

In his January 3, 2012 report, Dr. Blum, the medical adviser, noted his review of Dr. Sklar's report. He agreed with Dr. Sklar's analysis under Table 15-3, Table 15-5 and Table 15-23, the grade modifiers and net adjustment formula. Dr. Blum also agreed with Dr. Sklar's conclusion that appellant had six percent right upper extremity impairment and five percent impairment on the left due to bilateral shoulder impingement syndrome, right de Quervain's tendinitis and bilateral carpal tunnel syndrome.

The Board finds that the record supports that appellant has no more than a six percent right upper extremity impairment and a five percent impairment on the left, for which she 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 appellant has no more than a six percent right upper extremity impairment and five percent impairment on the left.

ORDER

IT IS HEREBY ORDERED THAT the January 23, 2012 decision of the Office of Workers' Compensation is affirmed.

Issued: September 21, 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