United States Department of Labor
Employees' Compensation Appeals Board

S.P., Appellant	)	
and	)	**Docket No. 12-1442**
	)	**Issued: January 11, 2013**
U.S. POSTAL SERVICE, POST OFFICE, North Metro, GA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 21, 2012 appellant filed a timely appeal from a March 12, 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 this case.

ISSUE

The issue is whether appellant has more than a two percent impairment of his right or left arms, for which he received schedule awards.

FACTUAL HISTORY

On May 10, 2011 appellant, then a 50-year-old city carrier, filed an occupational disease claim (Form CA-2) alleging carpal tunnel syndrome as a result of heavy lifting, twisting and

[1] 5 U.S.C. § 8101 *et seq.*

turning high volumes of mail with his fingers. He first became aware of his condition and of its relationship to his employment on January 10, 2011.

On July 20, 2011 OWCP accepted appellant's claim for bilateral carpal tunnel syndrome. It authorized surgery for left carpal tunnel release which appellant underwent on August 18, 2011. OWCP also authorized surgery for right carpal tunnel release which he underwent on September 12, 2011.

In a February 6, 2012 medical report, Dr. David A. Schiff, Board-certified in pain medicine, provided an electromyogram (EMG) consultation per the request of Dr. Stephen M. McCollum, a Board-certified orthopedic surgeon and appellant's treating physician. He reported that appellant underwent prior EMG studies on May 25, 2010 which showed severe bilateral carpal tunnel syndrome on a polyneuropathy. Dr. Schiff noted that appellant underwent carpal tunnel release in 2011, resulting in partial relief of his hand symptoms though he continued to experience numbness and tingling in his fingers and hands. Upon review of appellant's February 6, 2012 EMG studies, he diagnosed moderate bilateral carpal tunnel syndrome, noting that the condition had improved over the preoperative findings. Dr. Schiff diagnosed bilateral cubital tunnel syndrome, noting the slowing of bilateral ulnar motor velocities across the elbow segments. He stated that there was prior evidence of polyneuropathy, but that his current examination showed that appellant's radial and ulnar sensory responses were normal whereas before they were delayed. Dr. Schiff attached appellant's February 6, 2012 EMG studies with his report.

In a February 14, 2012 medical report, Dr. McCollum reported that appellant underwent EMG nerve conductions on February 6, 2012 which demonstrated bilateral cubital tunnel syndrome with a conduction velocity of 42.6 meters per second across the elbow at the ulnar nerve on the left and 44 meters per second on the right, with lower limits of normal being 53 meters per second. Appellant stated that he experienced numbness and tingling prior to his carpal tunnel release. Postsurgery, he stated that his condition briefly improved but that four weeks later the numbness and tingling returned prior to returning to work. After returning to work, appellant developed slight increased numbness in his index, middle and ring fingers. Dr. McCollum stated that appellant's biggest problem appeared to be his ulnar sensory deficit aggravated by his work. Physical examination revealed no clawing, full digital composite flexion/extension and very positive Tinel's over Zones 2 and 3 of both cubital tunnels with positive elbow flexion tests. Dr. McCollum rated a two percent permanent impairment to both upper extremities as it related to carpal tunnel syndrome only.

On February 19, 2012 appellant filed a schedule award claim.

On February 27, 2012 OWCP routed Dr. McCollum's report, a statement of accepted facts and the case file to a district medical adviser (DMA) for review and a determination as to whether appellant sustained a permanent partial impairment and the date of maximum medical improvement. In the February 27, 2012 report, the DMA reported that appellant reached maximum medical improvement (MMI) on February 14, 2012. He noted that the May 25, 2010 EMG study revealed bilateral median nerve carpal tunnel syndrome superimposed on a peripheral neuropathy. The DMA also reported that left carpal tunnel release was performed on August 19, 2011 and right carpal tunnel release on September 12, 2011, noting that appellant

showed improvement postsurgery. He further stated that appellant's attending physician provided an excellent report and recommended two percent permanent impairment for each extremity. The DMA concluded that this was correct and consistent with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[2] finding a schedule award for two percent permanent impairment of the right and left upper extremities.

By decision dated March 12, 2012, OWCP granted appellant schedule award claims for two percent permanent impairment of the right and left upper extremities. The date of maximum medical improvement was noted as February 14, 2012. The awards covered a period of 12.48 weeks from February 14 to May 11, 2012.

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 or loss of use of scheduled members or functions of the body.[3] 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.[4]

The A.M.A., *Guides* provide a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[5] 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).[6] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[7]

Impairment due to carpal tunnel syndromes evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[8] In Table 15-23, grade modifier levels (ranging from 0 to 4) are described for the categories

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

[3] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[4] *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).

[5] A.M.A., *Guides*, *supra* note 2 at 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

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

[7] *Id.* at 411.

[8] *Id.* at 449.

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.[9]

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.[10]

ANALYSIS

OWCP accepted appellant's claim for bilateral carpal tunnel syndrome. The issue is whether appellant sustained more than a two percent permanent impairment of the left upper extremity and two percent permanent impairment of the right upper extremity for which he received schedule awards. The Board finds that appellant has not established that he has impairment of the upper right extremity greater than two percent and impairment of the left upper extremity greater than the two percent already awarded.

In a February 14, 2012 medical report, Dr. McCollum stated that appellant underwent EMG nerve conductions on February 6, 2012 which demonstrated bilateral cubital tunnel syndrome. Appellant reported experiencing numbness and tingling prior to his carpal tunnel release, his condition only briefly improving post surgery. After returning to work, he developed slight increased numbness in his index, middle and ring fingers. Dr. McCollum stated that appellant's biggest problem appeared to be his ulnar sensory deficit aggravated by his work. Physical examination revealed no clawing, full digital composite flexion/extension and very positive Tinel's over Zones 2 and 3 of both cubital tunnels with positive elbow flexion tests. Dr. McCollum found that appellant had a two percent impairment of both upper extremities.

OWCP properly referred the case record to the DMA for review and a determination on whether appellant sustained a permanent partial impairment and date of maximum medical improvement. In his February 27, 2012 report, the DMA reported that appellant reached maximum medical improvement on February 14, 2012, the date Dr. McCollum evaluated appellant and provided his impairment rating. He noted that the May 25, 2010 EMG study revealed bilateral median nerve carpal tunnel syndrome superimposed on a peripheral neuropathy. The DMA reported that left carpal tunnel release was performed on August 19, 2011 and right carpal tunnel release on September 12, 2011, noting that appellant showed improvement post surgery. He reviewed Dr. McCollum's report and agreed with the two percent impairment ratings of each arm under the sixth edition of the A.M.A., *Guides*.[11]

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

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

[11] A.M.A., *Guides* (2009).

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 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.[13]

Dr. McCollum provided a detailed pre and postoperative history, examination findings and EMG nerve conduction studies regarding appellant's upper extremities. He used these findings to calculate an impairment rating for permanent residuals of the right and left carpal tunnel syndrome. Using Table 15-23 of the A.M.A., *Guides*, Dr. McCollum used appellant's test findings, history and physical findings to determine that appellant's left upper extremity impairment averaged to a grade modifier of 1. Appellant's right upper extremity impairment also averaged as grade 1 for the final rating category. According to Table 15-23, a grade modifier 1 has an upper extremity impairment rating of one to three percent. Thus, Dr. McCollum concluded that appellant had two percent upper right extremity impairment and two percent upper left extremity impairment due to carpal tunnel syndrome.[14]

The Board finds that the DMA properly reviewed Dr. McCollum's report and applied the appropriate tables and grading schemes of the A.M.A., *Guides* in determining that appellant had no more than a two percent permanent impairment for each upper extremity for which he received a schedule award. Moreover, the date of MMI was correctly noted as February 14, 2012 as the determination of the date ultimately rests with the medical evidence[15] and is usually considered to be the date of the evaluation by the physician which is accepted as definitive by OWCP.[16] Appellant did not submit any additional medical evidence on appeal which would establish that he has more than two percent impairment to the upper right extremity and two percent permanent impairment to the upper left extremity.

On appeal, appellant contends that he continues to experience problems with his left and right hand but did not challenge the extent of impairment. As set forth above, he did not submit probative medical evidence supporting greater percentages of impairment than those awarded.

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.

[12] *Id.* at 449.

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

[14] *Id.* at 448-49, Table 15-23.

[15] *L.H.*, 58 ECAB 561 (2007).

[16] *Mark Holloway*, 55 ECAB 321, 325 (2004).

CONCLUSION

The Board finds that appellant has not established that he has more than a two percent permanent impairment of the left upper extremity and two percent permanent impairment of the right upper extremity, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decision dated March 12, 2012 is affirmed.

Issued: January 11, 2013
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

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

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